

**THE COLONIAL MEDICAL OFFICER
AND COLONIAL IDENTITY:**

**KENYA, UGANDA AND TANZANIA
BEFORE WORLD WAR TWO**

by

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Abstract

The Colonial Medical Service was the branch of the Colonial Service responsible for healthcare provision in the British overseas territories. This work profiles Colonial Medical Officers serving in Kenya, Uganda and Tanzania from the beginnings of British colonial rule to the start of World War Two. On the basis of a large prosopographical database, the composition and experiences of this governmental cadre are profiled and analysed.

The work is divided into two substantive parts: entering the Colonial Medical Service and experiencing the colonial medical career. The first looks at how doctors joined the Service, what the objective and subjective criteria for recruitment were and how these criteria influenced the types of individuals that were recruited. Then reasons for entering the Service are analysed, particularly looking at explanations from officers as well as examining broader contextual factors that may have stimulated recruitment. The second part of the work focuses upon the experiences specific to being a Medical Officer once arrived in East Africa. It outlines job descriptions and typical duties as well as the common experiences Officers were likely to have and how these changed over time. Special attention is paid to the way colonial life demanded particular characteristics, ones stressed during the recruitment process and by the appointees themselves as defining the job as a particularly 'different' choice for medical graduates. This reflection over the shared professional encounters moves to an argument for the development of a distinct colonial medical identity, arguing that the sense of common mission and the shared experiences of the colonial medical cohort bound Officers together symbolically in a progressive British (political and medical) project. This formation of distinct colonial identities relied upon various (although also unifying) factors of race, situation, employer, profession and medical interests. The resulting sense of kinship both determined, and also to some degree regulated, colonial medical attitudes and behaviour.

Table of Contents

List of Figures	5
Acknowledgements	7
Key to Abbreviations	9
Explanatory Notes	13
1. Introduction	15
1.1 Aims and Remit	15
1.2 Historical Background	18
1.3 Historiography	34
2. Joining the Colonial Medical Service	48
2.1 Recruitment into the Colonial Service	49
2.2 Recruitment into the Colonial Medical Service	60
2.3 The Subjective Side to the Selection Process	71
2.4 Recruitment Trends	84
2.5 Terms and Conditions of Colonial Medical Employment	92
3. Reasons for Being a Doctor in East Africa	102
3.1 The Economic Factor	104
3.2 Practical Considerations and the Social Factor	112
3.3 Connections	121
3.4 The Religious Factor	126
3.5 The Adventure Factor	131
3.6 The Professional Factor	140
3.7 Other Reasons	146
4. Colonial Medical Experiences	151
4.1 Organisation of the Colonial Medical Service	154
4.2 The Organisation and Focus of Colonial Medicine	168
4.3 Common Career Experiences	179
4.4 Women in the Colonial Medical Service	201
5. Colonial Medical Identities	210
5.1 The Colonial Service Stereotype	211
5.2 The Colonial Medical Service: The Prosopographical Results	216
5.3 Colonial Medical Communities	231
6. Conclusion	265

6.1 The Stories That Have and Have Not Been Told	265
6.2 The Post-War Period	268
6.3 Career, Place and Identity	274
Appendix 1	278
A Note on the Prosopography	278
Appendix 2	281
Heads of the Medical Departments	281
Appendix 3	282
Service Dates of MOs Kenya, Uganda & Tanzania: 1893–1939	282
Appendix 4	292
Obituary/Biographical Entry Index	292
Appendix 5	296
75 Case Studies	296
Appendix 6	320
Distribution of Medical Officers in East Africa 1893–1939	320
Appendix 7	321
General Colonial Service Recruitment: 1913, 1919–1939	321
Bibliography	323

List of Figures

Figure 2.1: Appointment Enquiries for the Colonial Service, 1902–12, 1914	85
Figure 4.1: Gender Distribution in EAMS, 1893–1939	203
Figure 5.1: National Distribution of MOs' Qualifications	219
Table 5.1: MOs Highest Medical Qualifications	223
Table 5.2: Place of Origin of Highest Medical Qualification	225
Table 5.3: Age of Entry to EAMS	226
Table 5.4: Length of Service in East Africa	228

*I believe it is possible that at some future date, after my time,
someone may be prompted to write a history of the Colonial
Medical Service, for which I have a very great pride and
affection.**

* RHL/MSS.Afr.s.1653, TF Anderson, *Reminiscences by T Farnworth Anderson*, Book I, Kenya, 1973, Foreword

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else, made me believe in my abilities and has been, in every way, the best teacher of all.

Key to Abbreviations

Libraries and Archives:

BL	British Library [London, UK]
BMA	British Medical Association Archives [London, UK]
CMAC	Contemporary Medical Archive Centre [Wellcome Trust]
FCO	Foreign and Commonwealth Office Library [London,
KNA	Kenya National Archives [Nairobi, Kenya]
LSHTM	London School of Hygiene and Tropical Medicine
ORDP	Oxford Development Records Project [Rhodes House]
PRO	Public Record Office [Kew, Surrey, UK]
RHL	Rhodes House Library [Oxford, UK]
WL	Wellcome Library for the History of Medicine [London,

Journal Titles:

AA	<i>African Affairs</i>
AR&D	<i>African Research and Documentation</i>
ASR	<i>African Studies Review</i>
AHR	<i>American Historical Review</i>
AJS	<i>American Journal of Sociology</i>
APSR	<i>American Political Science Review</i>
BMJ	<i>British Medical Journal</i>
BJHS	<i>British Journal for the History of Science</i>
BHM	<i>Bulletin of the History of Medicine</i>
CJAS	<i>Canadian Journal of African Studies</i>
CS Club Mag.	<i>The Colonial Service Club Magazine</i>
EAMJ	<i>East African Medical Journal</i>
Emp.Rev.	<i>Empire Review</i>
EHR	<i>English Historical Review</i>
GMJ	<i>Glasgow Medical Journal</i>
HS	<i>History of Science</i>
IJPA	<i>The Indian Journal of Public Administration</i>

JAA	<i>Journal of African Administration</i>
JAH	<i>Journal of African History</i>
JBS	<i>Journal of British Studies</i>
JHB	<i>Journal of the History of Biology</i>
JICH	<i>The Journal of Imperial and Commonwealth History</i>
JIH	<i>The Journal of Interdisciplinary History</i>
JMAS	<i>Journal of Modern African Studies</i>
JMH	<i>The Journal of Modern History</i>
JRAS	<i>Journal of the Royal African Society</i>
JRSA	<i>Journal of Royal Society of Arts</i>
KEAMJ	<i>Kenya and East African Medical Journal</i>
KMJ	<i>Kenya Medical Journal</i>
Lit.&Anthrop.	<i>Literature and Anthropology</i>
MH	<i>Medical History</i>
Mod.AS	<i>Modern Asian Studies</i>
Nat.Rev.	<i>National Review</i>
Pr.RSEd.	<i>Proceedings of the Royal Society of Edinburgh</i>
SHM	<i>Social History of Medicine</i>
SAR	<i>South Asia Research</i>
StTHG	<i>St. Thomas' Hospital Gazette</i>
SHPBBS	<i>Studies in the History and Philosophy of Biological and Biomedical Sciences</i>
Tr.RHS	<i>Transactions of the Royal Historical Society</i>
Tr.RSTMH	<i>Transactions of the Royal Society of Tropical Medicine and</i>
UMJ	<i>The Ulster Medical Journal</i>
VS	<i>Victorian Studies</i>
WTRev.	<i>Wellcome Trust Review</i>
WMQ	<i>William and Mary Quarterly</i>

Other Bibliographical Abbreviations:

An.Med.Rep.	Annual Medical Report
Bl.Bk.	Blue Book
CO List	Colonial Office List

EAP Bl.Bk.	East Africa Protectorate Blue Book
EAP Gov.Gaz.	East Africa Protectorate Government Gazette
EA&U Gov.Gaz	East Africa and Uganda Government Gazette
KC Gov.Gaz.	Kenya Colony Government Gazette
Kenya Gov.Gaz.	Kenya Government Gazette
TT Gov.Gaz.	Tanganyika Territory Government Gazette
UP Bl.Bk.	Uganda Protectorate Blue Book
UP Gov.Gaz.	Uganda Protectorate Government Gazette

Organisations:

BMA	British Medical Association
CAS	Colonial Administrative Service
CMS	Church Missionary Society
CO	Colonial Office
IBEAC	Imperial British East Africa Company
ICS	Indian Civil Service
IMS	Indian Medical Service
RAMC	Royal Army Medical Corps

Job Titles:

CSO	Chief Sanitation Officer
DDMSS	Deputy Director of Medical and Sanitary Services
DDMS	Deputy Director of Medical Services
DDSS	Deputy Director of Sanitary Services
DDLs	Deputy Director of Laboratory Services
DL	Director of Laboratory
DMO	District Medical Officer
DMS	Director Medical Services
DMSS	Director of Medical and Sanitary Services
DO	District Officer (Administrative Service)
DPMO	Deputy Principal Medical Officer

DPSO	Deputy Principal Sanitation Officer
MO	Medical Officer
MOH	Medical Officer of Health
PMO	Principal Medical Officer
PSO	Principal Sanitation Officer
SMO	Senior Medical Officer

Qualifications:

DPH	Diploma in Public Health
DTH	Diploma in Tropical Health
DTM	Diploma in Tropical Medicine
DTM&H	Diploma in Tropical Medicine and Hygiene

Explanatory Notes

East Africa:

Although 'East Africa' includes Zanzibar, Nyasaland (British Central Africa, 1891–1907; Nyasaland 1907–1964; now Malawi) and British Somaliland (part of modern-day Somalia), it is used here as a general descriptor referring only to the largest three territories that form the basis of this study: Kenya, Tanzania and Uganda. I do not examine Somaliland, despite its inclusion in some contemporary definitions of British East Africa, largely because it is geographically separate from the three countries that inform this research. Long on-going border disputes with Italy placed British Somaliland at the Northern edge of the Kingdom of Ethiopia (modern-day Ethiopia) making it necessarily isolated from the other major East African countries. Furthermore, the number of MOs allocated there was extremely small: at the end of the period comprising only five officers.¹ Similarly, Nyasaland had only a comparatively small Medical Service (12 staff in 1914 compared with those of Kenya (31) and Uganda (26) in the same year).² In the Colonial Office mentality at least, the regional 'block' to which Nyasaland belonged was prone to change: although it was sometimes included in descriptions of East Africa, it was as often grouped together with Northern Rhodesia as part of Central Africa.³ Finally, this research has excluded the Sultanate of Zanzibar. Although interesting in its own right, the colonial medical organisation of the island is more likely to show divergence rather than similarities to the countries I have chosen to consider. Zanzibar became a protectorate in 1890 (and was transferred from the Foreign Office to the Colonial Office in 1913), but throughout the period a hereditary Sultan, advised by a British resident, ruled the Protectorate. Its Medical Service therefore did not have the typical administrative structure of officers answerable to a Governor with supreme power. Rather the Sultan maintained his dominance over the island.

¹ A Kirk-Greene, *On Crown Service: A History of HM Colonial and Overseas Civil Services, 1837–1997*, 1999, p.38, table 2.8 'Distribution of the Colonial Service in British Tropical Africa, c.1939'

² This is the earliest published regional staff list I have found. In the same year, 1914, Somaliland had 2 and Zanzibar had 5 Medical Department members. FCO *East African Staff List*, 1914

³ C Jeffries, *Partners For Progress: The Men and Women of the Colonial Service*, 1949, p.26

Finally, the choice of Kenya, Uganda and Tanzania supplements and invites comparison with the work of Ann Beck who has written the only monograph to date on the medical administrative history of the area.⁴ It seems appropriate, even though her focus is pointedly different from mine, to compare like with like.

Country Names:

At the time Tanzania was referred to as Tanganyika Territory; Kenya as British East Africa, East Africa Protectorate or Kenya Colony; and Uganda as Uganda Protectorate. Because the names changed within the period I have used the modern-day name for each country to avoid confusion.

Sometimes I have referred to the three countries collectively as ‘colonies’—although this is not strictly correct (Kenya was a Colony and Protectorate, Uganda a Protectorate and Tanzania a mandated territory). This seems to be acceptable given the contemporary perception that “from the administrative point of view... the distinction is of little or no practical importance”.⁵

Personal Names:

For easier reading, I do not disrupt the narrative by giving place and dates of service for each MO at each mention. This information can be found in Appendices 3 and 5. Additionally, the preferred given name (if known) of any MO is used rather than their full birth name (e.g. Colin Carothers rather than John Colin Dixon Carothers; Bagster Wilson rather than Donald Bagster Wilson). Although some women MOs made up the cohort, the gender specific ‘he’ is sometimes used for stylistic purpose.

Bibliographical Note:

Place of publication is London unless specified. A list of abbreviations used within the footnotes can be found in the preceding Key to Abbreviations.

⁴ That is the only secondary source; there have been several participants’ memoirs and histories. A Beck, *A History of the British Medical Administration of East Africa: 1900–1950*, Cambridge, MA, 1999 [1970]

⁵ Jeffries, *Partners For Progress*, p.24

1. Introduction

[A] body of men whose collective experience far outsteps [*sic.*] the bounds of any single Dependency.¹

1.1 Aims and Remit

Former Colonial Medical Officer (MO) Arthur Williams summed up his reasons for joining the Colonial Service concisely: although his family had no particular connections with the African continent, he had been “captivated and drawn by the idea of East Africa”.² This self-professed sense of captivation points directly to the issue that makes up the central thesis of this work, namely that at the very heart of the Colonial Medical Service career was a desire to enrol into a certain lifestyle. Participation in this life, furthermore, symbolised something markedly different from that offered by medical careers back at home. Working in Africa evoked potent images of adventure and allowed medical graduates, sometimes of quite modest backgrounds, to combine good works with an active participation in governance. For doctors particularly it was intimately associated with the practice of tropical medicine and offered professional scope and material for, as one MO put it, “clinical practice and epidemiological research undreamed of...in the UK”.³ Choosing the colonial medical career was choosing not only a professional, but also a social, political and cultural identity.

Williams was one of many former colonial servants who were invited in the early 1980s by the researchers on the Oxford Developments Records Project (ODRP) to contribute to the archive that was being assembled for Rhodes House Library. His comments are strikingly typical and, along with others contained within different archives or published sources, can be used to examine questions of culture within colonial history. From the end of the nineteenth century when British presence in

¹ W Ormsby-Gore, ‘Foreword’ in C Jeffries, *The Colonial Empire and its Civil Service*, Cambridge, 1938, pp.vii–xi, p.x

² RHL/MSS.Afr.s.1872/153a AW Williams, ‘Detailed Memoranda on Experiences in the Colonial Medical Service in Uganda and Tanganyika, 1931-1949’, [n.d. c.1983], p.1

³ RHL/MSS.Afr.s.1872/9 RE Barrett, ‘Memorandum on Experiences in the Colonial Medical Service in East Africa, 1928-55’, 1983, p.1

Africa became officially established, the Colonial Service offered one of the first practical opportunities for those who did not want to be missionaries to work there. The Empire beckoned to many people with its long associations with a Victorian tradition of adventure, while also affording active participation in a modern political project that was popularly — almost uniformly before 1939 — conceived as being a good thing, “destined to last forever”.⁴ Colonial medical careers in this context were loaded with powerful associations, uniquely combining a reverence for tradition with a desire to play a part in modernity. Although pay was poor, tours of service long, and health risks considerable, doctoring in Africa provided a prospect to escape the workaday concerns of home. Moreover, the perceived trials and risks actually further demarcated the place as interesting and alluringly different. As MO Robert Hennessey gracefully put it, it offered the chance to work in a location that was allegedly “seething with parasites...near some of the Great Lakes of Africa, overlooked by the Mountains of the Moon”.⁵

* * *

In 1938, Ormsby-Gore (later Lord Harlech), Secretary of State for the Colonies (1936–1938), wrote that no account of stewardship could be complete unless:

...it also takes notice of the agents employed by the trustees, the manner in which they were recruited, the conditions under which they serve, the rewards to which they may aspire, and the training under which they undergo in order to fit them for the diverse duties which they have to perform.⁶

This work aims to fulfil these criteria. Above all else, this is an exploration of the career experiences of a group of Colonial Service doctors. It makes no claims to offer a history of East African medical policy or procedure, although the findings naturally touch upon both.⁷ Rather, this is a cultural-historical enquiry into a particular

⁴ RHL/MSS.Afr.s.1653, TF Anderson, *Reminiscences by T Farnworth Anderson*, Book I, Kenya, 1973, p.14

⁵ RHL/MSS.Afr.s.1872/75 RS Hennessey, ‘Learning About Disease in Uganda: 1929–44 and 1949–55’, 1983, p.1

⁶ Ormsby-Gore, ‘Foreword’, p.vii

⁷ The medical history of East Africa has been traced elsewhere. See DF Clyde, *History of the Medical Services of Tanganyika*, Dar Es Salaam, 1962; A Beck, *A History of the British Medical Administration of*

government cohort: it asks who made up the cadre; how were they recruited and how they presented themselves in relation to their careers. Central to this analysis is the investigation of personal experiences, through participant memoirs and papers, contemporaneous commentaries on the Service within the medical literature, and the official files of the Colonial Office (CO) patronage and personnel divisions. The examination centres on common perceptions held about, and within, the Colonial Medical Service and relates these findings to broader social and cultural themes. The aim has been to project the career's attractions and experiences against its relevant context and to contribute to an emergent field within medical history that has recently begun to emphasise the intricate relationship between medicine, identity and colonialism.⁸ Thus, the argument is made for the development of a distinct colonial medical identity, shaped by a sense of common mission and shared experiences as well as recruitment policies, compliance with certain attitudes and behaviours, membership of the medical profession and the rise of tropical medicine as a new discipline.

This work constitutes the only detailed historical description of Colonial Medical Service recruitment policy and is the first to make active use of official and unofficial documentation to describe the changing nature of the official medical duties and expectations. A large database has enumerated and profiled the medically qualified personnel of the Colonial Medical Service in Kenya, Uganda and Tanzania, from the beginning of British rule in each place to the start of the Second World War. During this period 424 officers served in the medical corps. Each one has been traced to ascertain, at the very least, their educational record, and the progress of their colonial career.

East Africa: 1900–1950, Cambridge, MA, 1999 [1970]; JA Carman, *A Medical History of the Colony and Protectorate of Kenya: a Personal Memoir*, 1976; WD Foster, *The Early History of Scientific Medicine in Uganda*, Nairobi, 1970; O Ransford, *Bid the Sickness Cease: Disease in the History of Black Africa*, 1983 As well as the numerous detailed studies of particular health initiatives. Eg, J Iliffe, *East African Doctors: a History of the Modern Profession*, Cambridge, 1999; KA Hoppe, *Sleeping Sickness Control in British East Africa, 1900–1960*, Westport, CT, 2003

⁸ As will be examined in section 1.3, much has been written on the colonial identity, but very little on the specifically medical context. One recent exception is MP Sutphen and B Andrews (eds.), *Medicine and the Colonial Identity*, 2003

The resulting perspectives supplement other works within colonial medical history of East Africa — those looking, for example, at the history of therapeutics, the development of medical policies or the influence of indigenous peoples in directing colonial developments. By offering greater understanding of the backgrounds, experiences and attitudes of government doctors, it is hoped that the narrative will add to an informed understanding of colonial historical events. Moreover, detailed examination of the terms and conditions under which Medical Service members were employed will provide an insight into broader CO recruitment policies; revealing the ‘mindset’ of the CO as well as the common attitudes of Service officials. It is anticipated that many of the themes identified may not just be typical of East Africa or of medical workers, but may provide a cultural historical template with which to view the colonial experience in general.

This study is no apologist’s account. It does not aim to resurrect colonial officers as ‘misunderstood’; it does not deny that certain medical policies were ill-conceived, or even oppressive. In fact, it makes no particular comment on these aspects, which have already formed the basis of much rich scholarly investigation (see 1.3). The aim is to seek a greater understanding of the European perspective. By examining recruitment policy (Chapter 2), motives for joining the Medical Service (Chapter 3), common career experiences (Chapter 4) and the features of a colonial medical identity (Chapter 5), an important aspect of colonial history is placed within its proper cultural context.

1.2 Historical Background

The Colonial Service and the Colonial Medical Service

The Colonial Service constituted the staff of those British imperial territories that were administered first by the Foreign Office and later, after departmental organisations in the early 1900s, by the CO. While the CO officially oversaw the Colonial Service, the two organisations were nevertheless distinct. Simply put, the Colonial Service was made up of the personnel who oversaw the local administration of those British territories whose civil services were not otherwise administered

separately.⁹ Although they technically worked towards the same political ends, CO interests in the metropolitan ruling centre often clashed with the concerns of those who bore direct administrative responsibility abroad.¹⁰

Colonial Service personnel (apart from subordinate posts) were predominantly recruited in London, but once appointed officers were paid by, and immediately responsible to, the individual colonial governments they served. It was assumed that Britain's colonies should be largely self-supporting, principally through funds collected by local taxation imposed upon indigenous populations. Unsurprisingly, this led to frequent complaints from Colonial Service members that their pay, pensions and benefits were not equal to those of civil servants employed centrally by the CO.¹¹ In most respects, however, the relative independence that the Colonial Service enjoyed from central command was fêted rather than mourned. It was only in matters of extreme political importance, or in the case of very senior appointments, that CO approval had to be specifically sought. Mergers between the CO and the Colonial Service were discussed throughout the period, but perhaps because both parties tacitly acknowledged the benefits of independence, these plans never materialised.¹²

Although the Secretary of State for the Colonies and the CO had ultimate responsibility for the Colonial Service, the Governor of each colony had a powerful rôle. He was normally assisted by an advisory body called the Executive Council and a legislative body called the Legislative Council. These two Councils formulated policies and regulations for each territory.¹³ The Medical Department was one of the major departments of each colony; others included the Treasury, the Legal Department, the Customs Department, the Education Department, the Agricultural

⁹ The India Office governed British affairs in India (the Indian Civil Service was established in 1858). The Sudanese and Egyptian Services remained governed by the Foreign Office throughout the period (the Sudan Political Service was established in 1899, the Egyptian Civil Service in 1882)

¹⁰ R Hyam, 'The Colonial Office Mind 1900–1914', *JICH*, 8, 1979, pp.30–55, p.39

¹¹ T Clark, 'Chalk and Cheese? The Colonial and Diplomatic Services,' in J Smith (ed.), *Administering Empire: The British Colonial Service in Retrospect*, 1999, pp.49–59

¹² C Parkinson, *The Colonial Office From Within, 1909–1945*, 1947, pp.99–100

¹³ C Jeffries, *Partners For Progress: The Men and Women of the Colonial Service*, 1949, pp.59–60

Department and the Public Works Department.¹⁴ The head of each department was usually a member of the profession that they represented; the head of the Medical Department therefore was always a doctor.

Although the Colonial Service had been in existence since 1838,¹⁵ it was the appointment of Joseph Chamberlain (1836–1914) as Secretary of State in 1895 that marks the moment when the Colonial Service really began to become organised into an important career.¹⁶ Before Chamberlain's investiture, the CO was not considered an important branch of government, especially in comparison to the prestigious India Office that administered the affairs of the Raj. Under Chamberlain: "[a]ll obstructions were swept away ... typewriters were introduced, the maps were all renewed and gas lamps soon replaced the primitive illumination".¹⁷ Famously, Chamberlain's leading theory for imperial governance was 'constructive imperialism'. His initiatives on behalf of the Colonial Service were an integral part of this ideological framework that sought to draw the different parts of the Empire closer together for purposes of defence and commerce. Under his influence the control of most of the African territories was transferred from the Foreign Office to the CO. The power and remit of the CO was thus expanded and an immediate need was created for the administrative, legal and medical staff to be effectively organised.¹⁸

In order to streamline the bureaucracy of Empire, one of Chamberlain's first acts was to re-assess the extent and condition of the vaguely defined Colonial Service that he had inherited. He commissioned a survey under the guidance of Lord Selborne, the then Parliamentary Under-Secretary of State. Selborne's report (completed in 1899, returned to Chamberlain in 1900), indicated that there were substantial organisational problems inherent in the Service; not least large discrepancies between the various colonies themselves, which lacked coordination

¹⁴ For fuller description of colonial government structures see Jeffries, *Colonial Empire*, pp.93–104

¹⁵ In 1837 the first official usage of the label 'Colonial Service' has been identified by Kirk-Greene. A Kirk-Greene, *On Crown Service: A History of HM Colonial and Overseas Civil Services, 1837–1997*, 1999, p.8

¹⁶ Parkinson, *Colonial Office From Within*, p.17

¹⁷ P Manson-Bahr, *History of the School of Tropical Medicine in London: 1899–1949*, 1956, p.29

¹⁸ Kirk-Greene, *On Crown Service*, p.11

and standardisation. Chamberlain consequently set to work reorganising the administrative infrastructure, a task that particularly impacted the Medical Service which, it was estimated, comprised 447 officers, nearly a third of the Colonial Service.¹⁹

In Africa especially, where health problems loomed large, successful medical colonisation was recognised as one of the fundamental springboards by which to establish political objectives. As the *British Medical Journal (BMJ)* declared with respect to colonial ambitions in 1905: “the lancet is more powerful than the sword”.²⁰ Chamberlain clearly agreed and accordingly paid unprecedented attention to medical matters in connection with the colonial project. He appointed Patrick Manson (1844–1922), widely regarded as the most important doctor in the tropical medical field, as the first Consulting Physician for the CO and together they commenced plans to coordinate the training of MOs for the first time. As early as 1888, Chamberlain addressed the General Medical Council and the Deans of the principal medical schools in Britain putting forward his suggestion that all MOs in the Colonial Service should undertake a specialist course of study before embarkation abroad.²¹ It took over ten years for the plan to materialise, with the opening of the London and Liverpool Schools of Tropical Medicine in 1899. Principally because it was the brainchild of Chamberlain and Manson, the London School of Tropical Medicine was always more closely associated with the Colonial Medical Service career. Although the Liverpool School was also to offer a Diploma in Tropical Medicine to perspective MOs, its ethos was driven more by commercial interests than the political ideals of the British Government.²² It was from the London base that the first official organisation of a specific training facility for Colonial MOs was conceived. Other centralising features occurred later on, but this marks the true beginning for structured Colonial Medical Service careers.

¹⁹ *Ibid.*, p.16

²⁰ ‘Medical Science and Colonization’, *BMJ*, i, 1905, pp.1002–3, p.1002

²¹ HJO’D Burke-Gaffney, ‘The History of Medicine in the African Countries’, *MH*, 12, 1968, pp.31–41, pp.33–4

²² The Liverpool School was formed as a result of the philanthropy of a wealthy trading associate and formed a greater early interest in colonial public health than the London School. See H Power, *Tropical Medicine in the Twentieth Century. A History of the Liverpool School of Tropical Medicine*, 1999

Tropical medicine was at this time growing in stature. As early as 1895, Manson had initiated at St George's Hospital a course of twenty lectures on tropical diseases designed specifically for graduates who sought a career in the tropical world.²³ Chamberlain, meanwhile, viewed common medical training as an integral part of his wider campaign to reform and modernise the Colonial Service. (A general 1898 circular to colonial governors recommended not only more focus upon tropical medical training for prospective MOs, but also called for easing of cumbersome bureaucracies, notably by suggesting that colonial medical reports should be "recast on one uniform type").²⁴ The Service had commenced the slow but steady changes it was to undergo up to World War Two. The period saw the first real drawing together of the Colonial Medical Service as an organisational group. It is not surprising that this strong institutional identity, which the government had put so much effort into nurturing, became an important defining facet of the collective colonial medical identity.

It was during Chamberlain's period of tenure that increasing emphasis was put upon internal regulation. Medical consultants began to be regularly used to offer advice on Medical Service matters, such as recruitment or the way the Service was to be structured. Medical advisers with expertise in tropical medical matters were appointed in London, Liverpool, Edinburgh and Dublin, although it was not until 1926 that the official post of Chief Medical Adviser to the CO was established. With one exception, all Chief Medical Advisers were former Colonial MOs, drawing on their in-field experiences to help guide central government practice.²⁵

The Colonial Medical Service, although frequently referred to as one body, was in fact run country by country with each colony having its own Medical Service, often with slightly different terms and conditions of Service. Transfers, even between geographically contiguous territories were difficult to manage administratively, as pensions or leave entitlement had to be re-calculated. One of the earliest attempts to remedy this problem occurred in 1902 with the establishment of

²³ 'Instruction in Tropical Diseases,' *BMJ*, i, 1895, p.771

²⁴ Circular: Chamberlain to Governors of all Colonies, 28/05/1898, quoted in JWW Stephens, W Yorke and B Blacklock, *Liverpool School of Tropical Medicine, Historical Record: 1898-1920*, Liverpool, 1920, p.4

²⁵ Parkinson, *Colonial Office From Within*, p.25, p.57

the unified West African Medical Staff (WAMS).²⁶ This initiative united the medical services of Nigeria, Gold Coast, Sierra Leone and Gambia together under the management of one regional governing body. This scheme was a response to recruitment problems for West Africa, which had a notoriously unhealthy reputation. The unification scheme aimed to expand the number of recruits for the area by presenting the job in West Africa as a more attractive career prospect. It was a resounding success: appointments rose from 120 in 1905 to 170 in 1909. Indeed, the West African model became to be so highly revered that it was soon regarded as the template to which all Medical Services should aspire.²⁷ Despite this the East African service continued in its old ways for nearly twenty years. Although the Tropical African Services Committee in 1910 and the Egerton Committee in 1919 considered the idea of creating a unified Service, it was regarded as rather premature. Pay scales and conditions of service among colonial servants were considered to be too variable from territory to territory. Moreover, the exigencies of World War One made moves towards greater unification increasingly difficult. The Egerton committee did, however, recognise that regional Colonial Medical Services organised along similar lines to the WAMS would benefit the practicability, status and prestige of the Service overall. Although the time was not ripe for the formation of a unified Colonial Medical Service, it did conclude that an East African Medical Service (EAMS) would be a workable option. As a direct result of this enquiry a united EAMS was eventually created in 1921.²⁸ The committee also saw the need for centralised guidance for the medical services and suggested that a medical Director-General be appointed to oversee the regional services.²⁹ This came to fruition with the appointment of Thomas Stanton as the first Chief Medical Adviser to the Secretary of State in 1926.³⁰

²⁶ As will be described later, between 1903–8 there was an attempt to administer the Medical Departments of Kenya and Uganda jointly.

²⁷ Jeffries, *Colonial Empire*, pp.16–17

²⁸ Cmd.939 *Report of the Departmental Committee Appointed by the Secretary of State for the Colonies to Enquire into the Colonial Medical Services*, 1920, p.6

²⁹ *Ibid.*, pp.3–4

³⁰ Jeffries, *Colonial Empire*, pp.43–4

The real turning point in Colonial Service history occurred in 1930 when the Warren Fisher Committee met to discuss all aspects of the Colonial Services including recruitment, training and structure. Medical Service recruitment was specifically affected (see Chapter 2), but it changed the face of the whole Service by establishing a single unified Colonial Service with different vocational branches.³¹ The Colonial Administrative Service (CAS) was first established in 1932; the Colonial Medical Service two years later. By 1949 there were twenty branches of the unified British Colonial Service, including: the Colonial Legal Service; the Colonial Police Service; the CAS; the Colonial Veterinary Service, the Colonial Education Service and the Colonial Agricultural Service.³²

From this brief overview it can be seen that throughout the development of the Colonial Service the administration was working towards greater ideological unity and institutional uniformity. Great emphasis was put upon the merits of standardisation and this served to increasingly bind officers together and reinforce their professional similarities over and above their individual differences. How these administrative developments towards centralisation were played out in the regions can be appreciated by considering the early development of the Colonial Medical Service in East Africa.

The Colonial Medical Service in East Africa

More Colonial Service entrants were posted to Africa than to any other colony, so the continent consistently took the majority of candidates entering government service overseas. The largest vocational group recruited into the Colonial Service in tropical Africa were Administrative Officers who represented British rule and order in the localities. Doctors were the second largest group. Although some had been to East Africa as individual pioneers, or with expedition parties, medicine as a colonial career in East Africa effectively began in 1888.³³ This was the year that the Imperial

³¹ Jeffries, *Partners For Progress*, pp.41–58

³² A Kirk-Greene, *A Biographical Dictionary of the British Colonial Service, 1939–1966*, 1991, pp.v–vi

³³ Arthur Milne named John Smith (arrived 1876 in Mombassa to work in Uganda) as the first British MO in the region. Smith was followed two years later by the (then unqualified—although he later qualified from Edinburgh University), Dr Felkin. AD Milne, 'The Rise of the Colonial Medical Service', *KEAMJ*, 5, 1928–9, pp.50–8, pp.50–2

British East Africa Company (IBEAC), received its royal charter to trade in the region, bringing with it administrators, commercial managers, and the first government doctors to attend to the medical needs of British residents. Before the establishment of the IBEAC, the sparse European medical presence mainly consisted of missionaries. In particular, the base set up by the Church Missionary Society (CMS) at Mengo, which was synonymous with the work of Albert and (to a lesser extent) Howard Cook, became very important regionally.³⁴

The early government doctors worked for the IBEAC until the individual countries were officially incorporated into the British Empire. Uganda became a British Protectorate in 1893 and Kenya (British East Africa, East Africa Protectorate or after 1920, Kenya Colony) became a Colony in 1895. Both passed from Foreign Office to CO control in 1905. The mandate for Tanganyika Territory (modern-day Tanzania) was not granted until 1919 and was not effective until 1920. With the formalisation of British government rule, in 1895, the IBEAC was officially disbanded and many company doctors made the smooth transition from company employment to government service. The doctors that participated in this transition — Archibald Mackinnon, James MacPherson, Walter MacDonald and Robert Moffat — became the first East African Colonial MOs.³⁵ Titles changed, as did accountability, but in general the transition from one organisational body to another was seamless. The IBEAC staff was supplemented by a few local recruits to the newly-formed Colonial Medical Service; for example, by William Ansorge who had arrived in Kampala in 1894 and was looking for work in the area.³⁶

The new administration had only just formed when the region experienced a revolt among the Sudanese in Uganda. This war put great strains on the Medical Department during its formative years, creating an immediate need for more personnel and diverting energies to containing the rebellion, at the expense of longer-

³⁴ For a history of the Mengo mission see AR Cook, *Uganda Memories, 1897–1940*, Kampala, 1945

³⁵ Mackinnon was one of the earliest members of the IBEAC (1888–91) but temporarily moved to India, as a civil surgeon (1893–4). He returned to Uganda in 1894 as a MO, once British rule had been formally established there. ‘Archibald Mackinnon’, *Who Was Who, 1929–1940*, Vol. III, 1967 [1941], pp.871–2; Beck, *History of British Medical Administration*, p.8

³⁶ Ansorge was officially appointed in 1895.

term medical policies.³⁷ By 1898, however, the uprising was largely suppressed and Robert Moffat was appointed as the first Principal Medical Officer (PMO) of Uganda. The medical administration of the region became divided along colonial borders between Moffat in Uganda and Walter MacDonald, an ex-IBEAC official, in charge of Kenya since 1895.

During the early years of British rule the distinction between military and civil personnel, continued to be blurred. Military doctors had often been the first to lay the foundations of a medical infrastructure and in the transition to civil rule many simply transferred to civil posts.³⁸ Some effectively had both civil and military obligations, but by the end of the first decade of the twentieth century military commands had almost completely receded in favour of civil rule.³⁹

Another factor that changed the face of the country and also shaped the constitution of the early Colonial Medical Service was the building, between 1895 and 1901, of the Uganda railway that was to run from Mombasa, Kenya to Port Florence, Uganda. The railway company had its own medical staff under a separate PMO (Dr Sieveking),⁴⁰ but on completion of the railway in 1901 medical staff were absorbed into the Colonial Medical Service. Some Colonial Service doctors, including Drs Waters and Paget, came to the career via this route.⁴¹

Plainly, the early histories of the medical services in Kenya and Uganda were much intertwined. The IBEAC and the railway company had been responsible for both territories. Even when the countries were established as separate entities, the relationship between the two remained remarkably fluid. This sinuous association

³⁷ Milne, 'The Rise of the Colonial Medical Service', p.53

³⁸ Often MOs participated in local military campaigns. Eg, Arthur Bagshawe engaged in the Lango Expedition (1901) and the Anglo-German Boundary Commission (1902-4), since his employment as a MO in Uganda. Aubrey Hodges served in the Sudanese mutiny (1898) and, as well as being PMO of Uganda (1908-19), was the Lieutenant Colonel commanding the Uganda Medical Corps. 'Arthur Bagshawe', *Who Was Who, 1941-1950*, Vol. IV, 1980 [1952], p.47; 'Aubrey Hodges', *Ibid.*, p.549

³⁹ JL Gilks, 'The Medical Department and the Health Organization in Kenya, 1909-1933', *EAMJ*, 9, 1932-3, pp.340-54, p.345

⁴⁰ KNA/MOH/1/5517 untitled document [History of British Medical Administration in East Africa], [n.d. c.1909]

⁴¹ Milne, 'The Rise of the Colonial Medical Service', p.55; although another source gives this date of amalgamation of railway and government medical services as 1903. KNA/MOH/1/5517 History of British Medical Administration; HA Bödeker, 'Some Sidelights on Early Medical History in East Africa', *EAMJ*, 12, 1935-36, pp.100-7, p.105

culminated in the formal amalgamation of the two medical departments under the guidance of a single PMO (Robert Moffat and then James Will) between 1903–8, with the headquarters and the sole regional laboratory in Nairobi.⁴² The appointment of James Will in 1904 marked an important milestone in the organisational development of the Colonial Medical Service. Will had been originally seconded from the Royal Army Medical Corps (RAMC) where he had gained a broad experience in dealing with medical organisation. His successor, Dawson Milne, described him as a man who in the course of his short career “did much to engender that spirit [*sic.*] de corps without which no administration can be a success”.⁴³ It was in 1904, for example, that the grading of senior ranks with differentiated emoluments began and the first important departmental structures were put into place. Under Will the post of Deputy Principal Medical Officer (DPMO) was instituted and he made the first inroads into public health administration by appointing a Medical Officer of Health (MOH) for the Port of Mombassa, thereby establishing the rudiments of an early sanitation branch.⁴⁴ During Will’s tenure the first European Hospital was opened in Nairobi, plans for the first mental hospital were put in place, and the first laboratory facilities, dispensaries and native hospitals were opened. By the time he retired in 1909 the EAMS had rapidly grown, with a combined regional staff of 37 MOs, plus numerous support staff.⁴⁵ After 1908 the EAMS split once more into two distinct territorial medical services, each with characteristic ambitions and foci. Aubrey Hodges took the headship of the Uganda Medical Service in autumn of 1908 and Will continued administering the Kenyan branch until Arthur Milne succeeded to the position in 1909.

Since most of the early doctors came from the IBEAC background, it is unsurprising that the Colonial Medical Service initially continued the narrow IBEAC policy of providing healthcare exclusively for Europeans and their families in support of the burgeoning British infrastructure. The earliest Colonial MOs, to use the

⁴² A Hicks, ‘Forty Years of the British Medical Association (Kenya Branch)’, *EAMJ*, 38, 1961, pp.43–53, p.43

⁴³ Milne, ‘The Rise of the Colonial Medical Service’, p.56

⁴⁴ *Ibid.*, pp.56–7

⁴⁵ KNA/MOH/1/5517 History of British Medical Administration

words of Michael Worboys, “followed trade and the flag.”⁴⁶ This policy gradually widened to include the care of Africans working for Europeans and then to Africans in urban centres in general. It was not until after World War One that concerted policies were initiated to tackle the healthcare of African communities more generally.⁴⁷

During this early period doctors provided a predominantly clinical service. Much less money was spent on preventive medicine or on investigation into epidemic or pandemic disease. Research and sanitary expeditions from metropolitan institutions (such as the visit of William Simpson to advise on the sanitary condition of East Africa) concentrated accordingly upon economically important colonial towns and ports.⁴⁸ Consequently there was very little interest in healthcare in rural areas except in crisis situations when disease could affect the stability of the colonial regime, particularly through diminishing the productivity of its workforce. When wider campaigns were undertaken, such as those against sleeping sickness in Uganda (1901–14) or plague outbreaks in Kenya (intermittently between 1902 and 1913), they were crafted chiefly as responses to crisis, rather than the implementation of longer-term medical plans.

This type of medical administration largely occurred because, during the early years, the priority was the creation of an infrastructure. The first most important stage was the building of the Uganda railway, soon followed by the building of roads, the establishment of residential areas and the introduction of a telegraph and postal system.⁴⁹ Within the realm of medicine, hospitals, staff housing and early dispensaries all needed to be established, with early MOs often participating in their design and construction (Chapter 4). A few early hospitals, such as the CMS Hospital at Mengo (1897), had been established by the missions, but in general it was a government concern to provide for and oversee the establishment of medical

⁴⁶ M Worboys, ‘Colonial Medicine’ in R Cooter and J Pickstone (eds.), *Medicine in the Twentieth Century*, Amsterdam, 2000, pp.67–80, p.70

⁴⁷ Beck specifies 1918 as this turning point. Beck, *History of British Medical Administration*, p.200

⁴⁸ Worboys, ‘Colonial Medicine’, p.70

⁴⁹ Headrick has argued for the decisive role of technological, industrial and medical innovations in the nineteenth-century European conquest of Africa. DR Headrick, *The Tools of Empire: Technology and European Expansion in the Nineteenth Century*, Oxford, 1981

facilities.⁵⁰ Characteristically, European hospitals were usually founded before native ones and as a rule remained better equipped and serviced. During the first decade of British rule European hospitals were established at Mombasa, Entebbe and Nairobi.⁵¹ In the earliest years the only stations with dispensaries in the entire region were the coastal townships of Mombasa, Malindi and Lamu (all trading centres of the IBEAC). The first native hospital was in Fort Hall, although others soon followed at Kisumu and Mombasa.⁵²

When Tanzania became a British mandated territory in 1919 roads, government buildings and a telegraph system had already been established under German rule.⁵³ The first PMO, John Davey, could happily state that the British had “inherited from the Germans some medical buildings which compare favourably with any in Tropical Africa”.⁵⁴ Hospitals, notably those at Tabora, Ocean Road and Sewa Haji, were already in existence. There was a relatively well-stocked laboratory, founded in 1897, where Robert Koch (1843–1910) had researched malaria, and a rudimentary public health programme in the form of a smallpox vaccination campaign and a health office.⁵⁵

Over time the territories naturally developed their own medical agendas in line with local priorities. Each country was home to different indigenous peoples with their own cultures and customs; the geographical and economic features of each area were dramatically different. In Kenya the British presence seemed quite secure by the 1920s. The British government had backed schemes to encourage settlement through land grants in the country and, although plague outbursts were frequent and it suffered from endemic malaria, health risks were comparatively manageable.

⁵⁰ WD Foster, ‘The Mengo Medical School, Uganda’ in EE Sabben-Clare, DJ Bradley and K Kirkwood (eds.), *Health in Tropical Africa During the Colonial Period*, Oxford, 1980, pp.172–6, p.172

⁵¹ KNA/MOH/1/5517 History of British Medical Administration

⁵² Carman, *Medical History of Kenya*, p.6

⁵³ For the early development of medical infrastructure in German-ruled Tanganyika see A Beck, ‘The Role of Medicine in German East Africa,’ *BHM*, 45, 1971, pp.170–8, p.171; WU Eckart, *Medizin und Kolonialimperialismus, Deutschland, 1884–1945*, München, 1997

⁵⁴ Tanganyika Territory, *An.Med.Rep.* 1919, Dar Es Salaam, 1920, p.12 quoted in E Ferguson, *Colonialism, Health and Medicine in Tanganyika, 1885–1961*, Unpublished Research Paper, Dar Es Salaam, 1974, p.21

⁵⁵ Clyde, *History of the Medical Services of Tanganyika*, pp.103–4; R Titmuss, B Abel-Smith, G Macdonald, AW Williams, CH Wood, *The Health Services of Tanganyika: A Report to the Government*, 1964, p.2

Indeed, the Kenyan highlands, were presented as an ideal location for British life, offering a land of opportunity for aspiring settlers.⁵⁶ In contrast, Uganda lacked widespread European settlement, and avoided the 'settler issues' of Kenya. Uganda was, rather, characterised by a strong missionary presence that later formed into a nucleus of officials around Makerere. The establishment of tertiary education in the region arguably dominated all other considerations in the colony. A major shaper of health policy in Uganda was the hugely devastating sleeping sickness epidemic that occurred around the Northern shores of Lake Victoria between 1899 and 1905, killing around 250,000 people.⁵⁷ Following this devastating epidemic sleeping sickness controls continued to dominate the imperial agenda in Uganda throughout the colonial period.⁵⁸ Tanzania, where the European population was significantly reduced after the German defeat, had the smallest white community of the three countries under consideration. Moreover, the European inhabitants had less of a sense of permanence than their Kenyan and Ugandan counterparts precisely because it was a mandated territory rather than a direct British Colony with all the accoutrements of permanent rule. When Tanzania came under British control an eclectic mix of officers were drawn from all over the Empire and it took several years for the new medical administration to really gel.⁵⁹ As a large mandated territory with considerably more isolated stations and widely dispersed officers the European community was more scattered than in Kenya or Uganda. Nevertheless, colonial community ties were still remarkably strong.

Despite regional differences colonial life in British East Africa was established upon roughly similar lines and it is still possible to talk about the three countries as a united group. In 1924, several years after Tanzania joined the Empire, plans were revived to implement closer union between the three major East African territories. Although these plans never came to fruition, parliamentary discussion over official

⁵⁶ Lord Cranworth, 'The Public School Boy in East Africa', *Nat.Rev.*, 336, 1911, pp.992-1000; D Hall, 'Settlers' Problems in Kenya', *JRSA*, 78, 1930, pp.406-23, p.416

⁵⁷ Although estimates have varied to as high as 300,000. B Langlands, 'The Sleeping Sickness Epidemic of Uganda, 1900-1920', Paper presented at Makerere University, May 1967 cited in M Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940*, Cambridge, 2002 [1992], p.71

⁵⁸ Hoppe, *Sleeping Sickness Control in British East Africa*

⁵⁹ RHL/MSS.Brit.Emp.r.4, PA Clearkin, *Ramblings and Recollections of a Colonial Doctor 1913-58*, Book II, Durban, 1967, p.165

closer union — strenuously supported by the Governor of Kenya, Sir Edward Grigg (1925–30) — continued until 1931.⁶⁰ The idea was attractive since Kenya, Tanzania and Uganda shared borders with Lake Victoria at their geographical centre. Mombassa acted as a port of entry to the whole region, and the Uganda railway served as a vital link for commerce and politics. After 1922 trade and interchange between these three countries was facilitated through the introduction of a common currency (the East African Shilling) in the region. By 1949 all three regions were further united under a joint High Commission that oversaw common services such as communications, posts and telegraphs and research.⁶¹

The organisation of medical provision in Kenya, Uganda and Tanzania developed along similar lines. The early years were characterised in Kenya and Uganda by the rather *ad hoc* establishment of the medical administration, concentrating particularly on carving out a presence in urban centres and providing healthcare mainly to the European officialdom. After the mandate had been awarded to the British to rule Tanzania (1919), serious reappraisal began. From the early 1920s moves were made to broaden medical care and to streamline the administrative channels through which it was managed.⁶² The health of indigenous African communities moved further up the colonial agenda; colonial medical services were extended to rural areas, and schemes were initiated to train Africans as medical support staff. Bureaucracies were rationalized with more emphasis on the decentralisation of medical administration. Some responsibilities for public health and basic clinical medicine were delegated to native authorities, distancing central government from the minutiae of everyday affairs. Theoretically, this freed the headquarters from cumbersome routine bureaucracies and allowed them time to concentrate on the development of medical policies.⁶³ During this period documentation was standardised for the first time and administrative procedures were

⁶⁰ 'Papers Relating to the Close Union of Kenya, Uganda and the Tanganyika Territory, 1931; Joint Select Committee on Closer Union of East Africa', *Parliamentary Papers*, 7, 1930–1

⁶¹ Jeffries, *Partners For Progress*, p.30

⁶² PRO/CO/533/662 'East Africa Medical Staff Regulations', 1926–7

⁶³ KNA/MOH/1/3906 Circular Despatch: 'Administration Decentralisation Scheme', 3rd August 1922

reassessed, moves were also made towards standardising the nomenclature of medical job titles throughout the British territories.⁶⁴

The impetus for this radical overhaul after World War One can be best understood as part of the prevailing political mood. In the 1920s colonial governments in East Africa began to reflect upon their relationship to the people they governed, and to draw up statements of the ideal considerations and responsibilities of a colonial government.⁶⁵ Although still self-serving and overbearingly colonial, with few concessions to local governance, a marked change in the rhetoric of colonialism was evident. East African colonial governments moved away from top-heavy European administration and began to favour systems of indirect rule as devised and practised by Sir Frederick Lugard (1858–1945) while High Commissioner in Nigeria (1900–7). This became the favoured model of British colonial governance, distinct from the French and Portuguese system of *administration directe* that aimed for the complete assimilation of colonial dependencies with the government systems of the ruling country.⁶⁶ As a means of implementing indirect rule within East Africa, the political administrations of Kenya, Uganda and Tanzania were divided up into regional blocks formally under the charge of British district administrators working in coordination with officially appointed native authorities. Demarcation of areas assigned to local control were made according to assumptions (subsequently found to be misinformed) that tribal affiliations were geographically fixed. Even the Kingdom of Buganda in Uganda Protectorate, which had traditionally had a ‘special’ relationship with its British masters, became assimilated into this idealised model of indirect governance after World War One.⁶⁷ Tanzania presented in some ways the most difficult case. German rule had divided Tanzania (Deutsches Ost Afrika) into administrative divisions called ‘akidas’, but rather than use these existing district divisions as the template for their

⁶⁴ KNA/MOH/1/3580 Circular Despatch: to all Heads of Departments, Senior Commissioners and Resident Commissioners, 16/10/1925

⁶⁵ PRO/CO/737/11 ‘Memorandum on Native Policy in East Africa’, *Special Supplement TT Gov. Gaz.*, 27/06/1930, pp.1–12 This reiterated the policy declaration originally made by the Duke of Devonshire in a 1923 white paper on East Africa [cmd.1922]

⁶⁶ B Berman and J Lonsdale, *Unhappy Valley: Conflict in Kenya and Africa, Book 1: State and Class*, 1992, pp.160–1

⁶⁷ AA Boahen (ed.), *Africa Under Colonial Domination 1880–1935*, Berkeley, CA, 1990, pp.142–52, p.147

own version of indirect rule, the British (reflecting a nationalistic, anti-German agenda) sought to reorganise local government in ways supposedly reflective of earlier 'natural' tribal boundaries. The result paid no heed to government systems that local people had become accustomed to under German rule and imposed new tribal delineations that took no account of a rapidly emergent complex series of Tanzanian identities.⁶⁸

The organisation of medical services after 1920 followed the pattern of the political reorganisation of district administration. The increased reliance indirect rule put upon native authorities was reflected within the medical sphere, with Native Authority Ordinances stipulating their responsibilities for the supervision, regulation and funding of health in each locality.⁶⁹ This was partially a pragmatic response since the ever expanding European populations of the three countries demanded an effectively organised health infrastructure, but it was also a reaction to the increased scrutiny colonial medical departments underwent after the First World War to provide healthcare facilities to Africans.

Although health emergencies and long-term priorities differed between the three territories, similarities in the general trajectory of medical development can be easily discerned. The East African region presented a comprehensive administrative unit: the same British government body ran the Colonial Service throughout Empire and the structures of all medical departments were broadly uniform. All Service positions were filled through the same recruitment procedure and there is evidence that, even during the early period, the colonies were regarded in official mentality as existing in uniform regional blocks.⁷⁰ Even before the official moves towards closer unification, when arranging transfers could be administratively awkward, officers were often moved, especially between contiguous colonies. The importance of the career as a binding agent was something that official pronouncements increasingly

⁶⁸ J Iliffe, *A Modern History of Tanganyika*, Cambridge, 1994 [1979], pp.322–5

⁶⁹ The Native Authority (Amendment) Ordinance, 1924 empowered native councils "to pass resolutions and to impose and collect rates for, among other purposes, the engagement of public health staff and the promotion of public health within the area under their jurisdiction". Colony and Protectorate of Kenya, *An.Med.Rep.*, 1936, Nairobi, 1937, p.3; PRO/CO/737/1 'Native Authority Ordinance, 1923', *TT Gov.Gaz.*, 24/08/1923, pp.495–500; PRO/CO/737/4 'Native Authority Ordinance, 1926' *TT Gov.Gaz., Supplement*, 01/10/1926, pp.54–63; The Uganda Native Authority Ordinance was passed in 1919.

⁷⁰ 'Information as to Colonial Appointments', *CO List*, 1908, pp.443–6, p.443

emphasised, especially after the recommendations of the Warren Fisher Committee. In July 1930 the Secretary of State, Lord Passfield (1859–1931) acknowledged that the government could not “help the diversities of climate and local conditions” but declared that the government would do as much as it could to foster homogeneity under the umbrella of the Colonial Service.⁷¹

The colonial medical career unified individuals more than it divided them. This work will describe how this unification went beyond the institutional and will illustrate how Colonial MOs enrolled in a lifestyle that tacitly and explicitly embraced common attitudes and behaviours. This analysis acknowledges the way Empire was culturally understood at the time. However crudely generalised the assumption may seem today, before World War Two Empire was popularly and officially seen as a single entity, or at the very least a series of regional blocks (East Africa, West Africa, the Far East). The Empire was a manifestation of British rule and British pride rather than a series of different countries with individual characters, both from the perspective of the people taking part in the imperial adventure and the British public they left at home.

1.3 Historiography

Several important histories of the Colonial Service have provided crucial building blocks to this study. The work of Anthony Kirk-Greene, particularly, has done much to situate the development of the Colonial Service policies in London and to describe the work of district officials in the field and the nature of their experiences.⁷² Before Kirk-Greene’s contribution the only detailed sources were two officially commissioned histories from the 1930s.⁷³ In more recent years other Colonial Service histories have appeared, but less has been written about the history of the Colonial Medical Service *per se*.⁷⁴ When studies have considered the government

⁷¹ Lord Passfield, address to the Corona Club, 1930 quoted in Jeffries, *Colonial Empire*, p.68

⁷² His works are numerous, but of special significance see Kirk-Greene, *On Crown Service*; A Kirk-Greene, *Britain’s Imperial Administrators, 1858-1966*, 2000; A Kirk-Greene, *Symbol of Authority*, [forthcoming] December 2004

⁷³ A Bertram, *The Colonial Service*, Cambridge, 1930; Jeffries, *Colonial Empire*

⁷⁴ Smith (ed.), *Administering Empire*; see also the research project (2001–4), ‘Activities of the British Colonial Service Since 1945’, directed by Michael Twaddle, Institute of Commonwealth Studies. There

medical cadres specifically they have typically touched upon their wider imperial mission, with little or no consideration of their constitution and character.⁷⁵ This is surprising as the Colonial Medical Service, after the CAS, was the second largest recruiter of men to the Colonial Service. While Harrison and Crawford have specifically profiled the cohort of the Indian Medical Service (IMS), there is a conspicuous silence over their counterparts in Africa.⁷⁶

The paucity of Medical Service history contrasts with the abundance of colonial medical studies. Although these rarely comment on the profile of Colonial MOs they provide a detailed picture of the context in which the cohort existed. Much of the early medical history of Africa was penned by ex-participants reminiscing over the heydays of their careers and is often nostalgic or self-justificatory in tone. These biographies and histories should naturally be regarded with some caution, but they still retain a value for revealing contemporaneous attitudes and assumptions. Certainly, they provide a lens through which to view the lives of those who served in Africa and an insight into their perceived frustrations and pleasures.⁷⁷

Much of this early African medical history omitted to address vital contextual social and cultural influences upon medical policy. It saw colonial medical history in terms of the decisions of individual players (especially politicians) and international competition and economic motives, rather than as a questionable expression of

have been occasional histories of other Services; eg, GP West (ed.), *A History of the Overseas Veterinary Services*, 1973; DM Anderson and D Killingray (eds.), *Policing the Empire: Government, Authority and Control: 1830-1940*, Manchester, 1991

⁷⁵ R Schram, *A History of the Nigerian Health Services*, Ibadan, 1971; C Baker, 'The Government Medical Service in Malawi: an Administrative History, 1891-1974', *MH*, 1976, 20, pp.296-311; A Bayoumi, *The History of the Sudan Health Services*, Nairobi, 1979; H Bell, *Frontiers of Medicine in the Anglo-Egyptian Sudan*, Oxford, 1999

⁷⁶ DG Crawford, *A History of the Indian Medical Service, 1600-1913*, 1914; DG Crawford, *Roll of the Indian Medical Service, 1615-1930*, 1930; M Harrison, *Public Health in British India: Anglo-Indian Preventative Medicine 1859-1914*, Cambridge, 1994; the African medical cohort is briefly mentioned in J Farley, *Bilharzia: A History of Imperial Tropical Medicine*, Cambridge, 2003 [1991], pp.17-29; DM Haynes, *Imperial Medicine: Patrick Manson and the Conquest of Tropical Disease*, Philadelphia, PA, 2001, pp.128-38

⁷⁷ See for example, JS Boyd, 'Fifty Years of Tropical Medicine', *BMJ*, i, 1950, pp.37-43; PCC Garnham, 'Britain's Contribution to Tropical Medicine', *The Practitioner*, 201, 1968, pp.153-61; M Gelfand, *Tropical Victory: An Account of the Influence of Medicine on the History of Southern Rhodesia, 1890-1923*, Cape Town 1953; Sabben-Clare, Bradley and Kirkwood (eds.), *Health in Tropical Africa*; Clyde, *History of the Medical Services of Tanganyika*; Carman, *Medical History of Kenya*; Foster, *Early History of Scientific Medicine in Uganda*

imperial priorities or an interplay of cultures within a rigid political model. In response to this, during the late 1970s and early 1980s a whole tranche of new historical analysis emerged which re-examined the relationships between colonialism, science and medicine. Leading monographs in this field (partly informed by a new post-colonial critique famously led by Franz Fanon⁷⁸) stressed for the first time the way colonial interventions had actually worsened the health situation in the African continent. It depicted medicine as a tool of the British political state, and sought to attribute rationales to the development of medicine in the colonies beyond the purely humanitarian. These works highlighted the ostensibly innocuous medical policies that supported the broader political, economic and social objectives of European colonisers.⁷⁹

Recently, the findings of these historians have been supplemented by work that acknowledges local responses. Rather than characterising colonialism simply as the imposition of western medical values from above, this supplementary work highlights the significance of ‘bottom-up’ initiatives by indigenous peoples, the rôle of local resistance, or the interchange of theories and traditions in influencing eventual medical practices.⁸⁰ Colonial medicine is seen as a two-way negotiation of medical knowledge that took place as much “on the initiative of the cultural borrowers as...the cultural transmitters”.⁸¹ Some historians took these ideas of multi-causality further by enrolling anthropological research to emphasise the cultural

⁷⁸ F Fanon, ‘Medicine and Colonialism’ in J Ehrenreich (ed.), *The Cultural Crisis of Modern Medicine*, New York, 1978, pp.229–51

⁷⁹ GW Hartwig and KD Paterson, *Disease in African History: An Introductory Survey and Case Studies*, Durham, NC, 1978; M Worboys, *Science and British Colonial Imperialism: 1895-1940*, University of Sussex, DPhil. Thesis, 1979; DR Headrick, *The Tools of Empire: Technology and European Expansion in the Nineteenth Century*, Oxford, 1981; R Macleod and M Lewis (eds.), *Disease Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion*, New York, 1988; AW Crosby, *Ecological Imperialism: The Biological Expansion of Europe 900–1900*, Cambridge, 1993

⁸⁰ R Packard, *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa*, Berkeley, CA, 1989; D Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-century India*, Berkeley, CA, 1993; Bell, *Frontiers of Medicine in Anglo-Egyptian Sudan*; Lyons, *The Colonial Disease*; Haynes, *Imperial Medicine*; G Ndege, *Health State and Society in Kenya*, Rochester, NY, 2001; M Echenberg, *Black Death, White Medicine: Bubonic Plague and the Politics of Public Health in Colonial Senegal, 1914–1945*, Portsmouth, NH, 2002

⁸¹ PD Curtin, *The World and the West*, Cambridge, 2000, p.109

contingency of all decisions about health, especially from the perspective of the colonised.⁸²

Of more direct relevance to this study are the works of Ann Beck, who between 1962 and 1981 contributed the largest academic analysis of the medical administration of Kenya, Tanzania and Uganda during the colonial period in two monographs and several journal articles.⁸³ Writing shortly after colonialism had crumbled in the region, Beck's historical examination described a linear trajectory of gradual medical improvements towards the eventual achievement of a mainly propitious medical situation in British East Africa. Even if colonialism was indubitably wrong, it was generally felt safe to extol, without shame, western medical advances in the continent as a positive colonial legacy.⁸⁴ The doctors she described were largely depicted (when described at all) as having chosen to work in Africa through genuine altruism or missionary-type zeal and there was little examination of the broader factors that may have informed their decisions and moulded their subsequent attitudes.⁸⁵

Beck is a useful starting point in that she looks at the influence of British medical policy upon the conduct of colonial governments, the role of financial restraints upon the conception and progress of health initiatives, and the change in medical foci in relation to local concerns. Her aims, however, are rather different those presented by this study. This work concentrates upon the Medical Service personnel themselves, the sorts of experiences they had and the cultural standards they represented. As one Colonial Service commentator put it:

⁸² M Vaughan, *Curing Their Ills: Colonial Power and African Illness*, Padstow, 1991; M Vaughan, 'Healing and Curing: issues in the Social History and Anthropology of Medicine in Africa', *SHM*, 1994, 7, pp.283-95; S Feierman and JM Janzen (eds.) *The Social Basis of Health and Healing in Africa*, Berkeley, CA, 1992

⁸³ A Beck, 'Problems of British Medical Administration in East Africa Between 1900-1930,' *BHM*, 36, 1962, pp.275-83; A Beck, 'Native Medical Services in British East Africa and Native Patterns of Society' in *Verhandlungen des XX Internationalen Kongresses für Geschichte der Medizin*, Hildesheim, 1968, pp.870-5; Beck, *History of British Medical Administration*; Beck, 'The Role of Medicine in German East Africa'; A Beck, 'Medical Administration and Medical Research in Developing Countries: Remarks on their History in Colonial East Africa', *BHM*, 46, 1972, pp.349-58; A Beck, 'The State and Medical Research. British Government Policy Toward Tropical Medicine in East Africa' in *Proceedings of the XXIII International Congress of the History of Medicine*, Vol. 1, 1974, pp.488-93; A Beck, *Medicine, Tradition and Development in Kenya and Tanzania, 1920-1970*, Waltham, MA, 1981

⁸⁴ Beck, *History of British Medical Administration*, p.208

⁸⁵ *Ibid.*, p.206

They [the governmental personnel] themselves were the government. Spread thinly over the ground, relying on their wits, personalities and physical stamina, they have embodied in their own persons virtually all the stuff and substance of rule....The ethos of government which they have been bequeathing to new States must be approached, therefore, through study of the administrative cadres themselves. In practice this means dealing with individuals where possible, their backgrounds, personalities and training, or at least with prototypes as defined by common denominators in the preparation and careers of significant members of Colonial civil servants.⁸⁶

In order to situate the specific argument to be made for the existence of a colonial medical identity, some of the academic perspectives that have been taken over the topic need to be examined. A formidable legacy of research within the closely related disciplines of cultural history and cultural anthropology is relevant to the analysis. Of particular interest are studies on the nature of nationalism in general or what it means to be British, or English, in particular.⁸⁷ It has become increasingly accepted that ideological bonds tied together otherwise disparate communities, over and above physical boundaries or other social and economic differences. Cultural anthropologists such as Clifford Geertz and Marshall Sahlins have emphasised that 'culture' is something that is actively performed by individuals. National identity is formed along certain familiar, scripted, lines and is actively — although not necessarily consciously — confirmed and substantiated through its practice and replication.⁸⁸ It is not necessary to dissect these explanatory models, but some of the ideas can be used pragmatically to underpin the collective traits of a specifically colonial medical identity. Interpretations that have been expressly offered within the realm of colonial studies are especially pertinent.⁸⁹

⁸⁶ R Heussler, 'Why Study the Colonial Service?', *Corona*, 13, 1961, pp.165–8, p.166

⁸⁷ B Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism*, 2002 [1983]; L Colley, *Britons: Forging the Nation 1707–1837*, 2003, [1992]; R Colls, *Identity of England*, Oxford, 2002; P Langford, *Englishness Identified: Manners and Character 1650–1850*, Oxford 2001 [2000] Although there have been counter arguments, eg, P Mandler, 'Against 'Englishness': English Culture and the Limits to Rural Nostalgia, 1850–1940', *Tr.RHS*, 7, 1997, pp.155–75

⁸⁸ C Geertz, *The Interpretation of Culture*, New York, 1973; M Sahlins, *Culture in Practice: Selected Essays*, New York, 2000. See also S Hall, "Who Needs Identity" in S Hall and P du Gay (eds), *Questions of Cultural Identity*, 1996, pp.1–17

⁸⁹ Many links between collective attitudes and careers are analysed by C Dewey, *Anglo-Indian Attitudes: The Mind of the Indian Civil Service*, 1993

Of seminal importance within this field is Edward Said's *Orientalism* (1978).⁹⁰ This work used the example of the East to argue for the emergence and expansion of literary, anthropological and linguistic conventions, from the eighteenth century onwards, to foster and demarcate ideas of western racial difference and superiority. Said claims that the western world had imaginatively subordinated the East via widely accepted academic and popular discourses. By presupposing eastern 'difference' as inherently worse, the West had effectively disempowered those that it ideologically had ambitions to colonise. This is not to say that the eastern world held no exotic enchantment for the west, but that it was usually compared or contrasted with the familiar western phenomenon, rather than celebrated in its own right.⁹¹ Above all else difference rather than similarity defined the Orientalist outlook — a theoretical perspective that initially focused upon the Arab world and later expanded to describe other Asian and African cultural encounters. Said's work has heavily influenced academic studies about colonial writing and the types of rhetoric associated with it.⁹²

More recently David Cannadine has countered Said's arguments of exported notions of 'difference' by highlighting the importance of exported ideas of 'sameness'. Cannadine's maintains that essentially British concepts of class, custom and pageantry were not only exported to (and magnified in) the colonial setting, but also that Crown representatives preferred to use familiar, traditional and nationally-based markers ultimately to define their relationship with those they ruled. British governance was comparatively respectful of indigenous models of governance with which it felt it could identify, however misconceived this was. This was particularly true of hereditary rulers in Africa or members of the higher castes in India. Cannadine has also argued for a shared collective vision in the colonial ruling classes, if not an actual shared collective class identity. Empire was seen to level out class

⁹⁰ EW Said, *Orientalism: Western Conceptions of the Orient*, Harmondsworth, 1995 [1978]

⁹¹ Something that Said subsequently expanded upon. E Said, *Culture and Imperialism*, 1993

⁹² For an early analysis of the rhetoric deployed in travel writing during the colonial period see D Hammond and A Jablow, *The Africa That Never Was: Four Centuries of British Writing About Africa*, New York, 1970. For works that derive from Said's, see ML Pratt, *Imperial Eyes: Travel Writing and Transculturation*, 1992; D Spurr, *The Rhetoric of Empire: Colonial Discourse in Journalism, Travel Writing and Imperial Administration*, Durham, NC, 1993

differences. Once settled abroad, colonials of various backgrounds assumed the trappings of an upper-middle class colonial tradition and shared a social position that would have been impossible to sustain at home.⁹³

This study builds on these central debates over whether group identities were created by the peculiarities of the colonial situation, or whether they were primarily replications of familiar, traditional cultures back home. Eric Hobsbawn and Terence Ranger have argued for a nuanced understanding of colonial identity, one that borrows from the home context as well as inventing traditions to fit the new one.⁹⁴ The imperial subject, dislocated from a familiar home milieu, imported to his new social, cultural, political and economic space communal presumptions and expectations that were adapted to the specificities of the colonial context. These in turn were ritualised through collective behaviour that both confirmed and extended group loyalties while simultaneously differentiating them from other groups, particularly indigenous ones. Furthermore, as Ranger has argued, colonial neo-traditional behaviour in Africa not only helped to define European relationships with the colonised, but was actively used by some African peoples to capitalise on the colonial situation for their own ends.⁹⁵ Traditions were invented by all sectors of colonial society as a means of confirming and extending collective identities.

These arguments, and others, stress how the political peculiarities of Empire brought about the development of widely dispersed micro-communities, all with joined allegiance to the British crown and core (albeit remoulded) British values.⁹⁶ At the same time, other important works have placed more emphasis on ubiquitous images of exoticism and difference in the creation of imperial identities.⁹⁷ From this perspective, conceptions of colonial identity have relied heavily upon prevailing

⁹³ D Cannadine, *Ornamentalism: How the British Saw Their Empire*, Harmondsworth, 2001

⁹⁴ E Hobsbawn and T Ranger (eds.), *The Invention of Tradition*, Cambridge, 2002 [1983]

⁹⁵ T Ranger, 'The Invention of Tradition in Colonial Africa' in *Ibid.*, pp.211–62; M Sahlins, 'Goodbye to Tristes Tropes: Ethnography in the Context of Modern World History', *JMH*, 65, 1993, pp.1–25

⁹⁶ See K Tidrick, *Empire and the English Character*, 1990; C Hall, *Civilising Subjects: Metropole and Colony in the English Imagination, 1830–1867*, Cambridge, 2002

⁹⁷ Driver has argued that there still is a romanticised reverence to the 'exotic' and deference to those who value exploration within contemporary culture. F Driver, *Geography Militant: Cultures of Exploration and Empire*, Oxford, 2001, pp.199–219

public enthusiasm for exotic images, particularly in travelling writing, colonial literature and journalism.⁹⁸ The CO utilised precisely these popular associations to stimulate recruitment to Empire careers (see Chapters 2 and 3). In important ways the popular paradigms of colonialism can be seen as self-fulfilling prophecies of what the colonial identity constituted during different times. The CO recruited a type; that type had certain common expectations (because they were selected using the same criteria) that in turn informed the wider colonial communities of which they were a part. Accordingly, the shared identities of Colonial MOs could be seen as intimately tied to popular conceptions of public servants and the colonial lifestyle they were expected to lead.⁹⁹ Furthermore, as Felix Driver has argued, the European in Africa attained great popular status because of the growing significance accorded to colonially-acquired expertise and knowledge attained through fieldwork and first-hand observation. These associations lent important cultural value to research in the exotic locations of Empire, notably for the furthering of modern metropolitan (in Driver's case, geographical; in this case, medical) knowledge.¹⁰⁰ Tropical medical expertise, or at least experience, was an important aspect of the colonial medical identity (see Chapter 5).

Complementing studies that rationalise and contextualise the reasons for, and constitution of, colonial identity, are detailed descriptions of colonial communities themselves. These are usually presented as a hybrid of exaggerated Britishness and specifically colonial exoticism. Some accounts have scrutinized the CO mindset in the moulding of London-based policies or the shared perspectives of CO employees.¹⁰¹ Other historians such as Alex McKay¹⁰² and Henrika Kuklick¹⁰³ have

⁹⁸ P Brantlinger, 'Victorians and Africans: The Genealogy of the Myth of the Dark Continent', *Critical Inquiry*, 1985, 12, pp.166–203; MacKenzie, *Propaganda and Empire: the Manipulation of British Public Opinion, 1880–1960*, Manchester, 1997 [1986]; Spurr, *Rhetoric of Empire*

⁹⁹ Driver has similarly argued for the status of explorers in the nineteenth century as also being based on a long tradition. Driver, *Geography Militant*, p.9

¹⁰⁰ Although, naturally, the growth of field-based expertise, was still reliant upon home institutions for funding, support and validation as well as reliant upon home-based traditions and fashions to extend their popularity.

¹⁰¹ Hyam, 'The Colonial Office Mind'; R Macleod (ed.), *Government and Expertise: Specialists, Administrators and Professionals 1860–1919*, Cambridge, 1983. To a lesser extent Haynes has done this for imperial medicine. Haynes, *Imperial Medicine*

¹⁰² A McKay, *Tibet and the British Raj: The Frontier Cadre, 1904–1947*, Richmond, Surrey, 1997

analysed specifically the careers of public servants, emphasising the influential factors of time and place in the development of close-knit colonial cadres.

Another important contribution that emphasises the importance of local context over external factors, is that of Dane Kennedy. Kennedy has presented a subtle picture of the “conformity of values and unanimity of purpose” espoused by the people that made up Kenyan and Rhodesian settler society.¹⁰⁴ The cultural communities that Kennedy described were the natural outcome of the negotiation of ideas between the colony and the metropolis. These were not only influenced by broader political obligations and theories of imperialism, but were also created locally in response to proximately gathered opinions and evidence. Rather than ideas being pure replicates, or exaggerations, of Britishness, home-grown values were often bent and even drastically distorted to present a homogenous colonial identity: an identity, moreover, that was articulated defensively precisely because it was associated with a demographic and racial minority.¹⁰⁵

One of the highlights of Kennedy’s work for the medical historian is the way it presents medical discourses — notably those about climate and regimens that should be adopted to ‘manage’ it — as revealing of the preoccupations and anxieties of settler society in general.¹⁰⁶ Somatic and psychological models of tropical health presented ideas that were anachronistic in the home setting (e.g. acclimatization theories), but unified people behind a justifiable orthodoxy in the colonial one. This constituted what Kennedy termed a “common culture”; one that was locally derived and which superseded other broader differences within colonial society.¹⁰⁷

While Kennedy has argued for the endurance of nineteenth-century ideas of acclimatisation in the colonial context, other authors have argued that medical and

¹⁰³ Kuklick’s work is heavily influenced by sociological sources. H Kuklick, *The Imperial Bureaucrat: The Colonial Administrative Service in the Gold Coast, 1920–1939*, Stanford, CA, 1979

¹⁰⁴ D Kennedy, *Islands of White: Settler Society and Culture in Kenya and Southern Rhodesia, 1890–1939*, Durham, NC, 1987, p.181; see also his work on the formation of colonial enclaves: D Kennedy, *The Magic Mountains: Hill Stations and the British Raj*, Berkeley, CA, 1996

¹⁰⁵ Furthermore, Kennedy argues that the success and perpetuation of these ideas partly depended upon the complicity and acceptance of these cultural expressions as either normal or desirable, by both the colonial rulers and the ruled. Kennedy, *Islands of White*, esp. pp.167–92

¹⁰⁶ *Ibid.*, pp.109–27

¹⁰⁷ *Ibid.*, p.8

scientific modernity (particularly the wonders of tropical medical) were used to define colonial communities and those they ruled. Several important works present imperial medicine as defining itself through modern 'rationality' and 'objectivity' as opposed to the superstition that was thought to dominate the 'primitive', non-scientific, indigenous cultures.¹⁰⁸ Megan Vaughan has examined the way western medicine influenced images of the African. She has concluded that one important non-variable, in an otherwise constantly shifting cultural and political landscape, was the over-riding idea of 'difference' that ultimately defined European-African encounters. The African was reduced to a pathological specimen, a creature of disease and dirt.¹⁰⁹ Interestingly, Vaughan also looked at popular images of European doctors in Africa, particularly the way the image of the hero-doctor further demarcated the relationship between British and African people.¹¹⁰

Finally, this relatively new cultural emphasis within medical history can be closely related to theoretical ideas on the formation of disciplines postulated within studies of cultural history, anthropology and science. Such arguments have emphasised how professional and social groups necessarily espouse certain ingrained values dedicated to the perpetuation and extension of that group's interests.¹¹¹ Barry Barnes has described how performance of certain group-affirming rituals can be seen as one of the reasons why strong place-specific identities develop.¹¹² Furthermore, as Roy Macleod has noted, colonial science was sometimes manifest in defining national characteristics. If Macleod's argument for the 'practical man' as the model Australian

¹⁰⁸ Not that that western medicine was always introduced uncontested. A Cunningham and B Andrews (eds.), *Western Medicine as Contested Knowledge*, Manchester, 1997

¹⁰⁹ Vaughan, *Curing Their Ills*, esp. pp.200-7. Similar issues have also been examined by P Curtin, 'Medical Knowledge and Urban Planning in Tropical Africa' *AHR*, 1985, 90, pp.594-613; W Anderson, 'Immunities of Empire: Race, Disease, and the New Tropical Medicine, 1900-1920' *BHM*, 70, 1996, pp. 94-118. This idea owes much to M Douglas, *Purity and Danger: an Analysis of Concepts of Pollution*, 1966

¹¹⁰ Vaughan, *Curing Their Ills*, pp.155-79

¹¹¹ Particularly work associated with the Strong Programme in the Sociology of Scientific Knowledge, especially D Bloor, *Knowledge and Social Imagery*, 1976 and B Barnes, *Interests and the Growth of Knowledge*, 1977

¹¹² B Barnes, *Elements of Social Theory*, 1996

scientist is followed, the tropical medical specialist could be seen equally as part of the scientific embodiment of a specifically tropical colonial medical identity.¹¹³

* * *

The academic debates outlined above have sought to rationalise the hitherto murky issues of how a colonial identity was created. The principal question is whether these common defining features were chiefly a means of self-definition or rather a means of defining the uncivilised 'other'. This discussion has also asked whether the specific medical manifestations of colonialism were as much about the sustainment of old traditions as the celebration of new ones; whether new values were inculcated as much to replicate home as they were to define a new location. These and similar questions provide a basis for a fresh evaluation of colonial medical identities.

Seemingly ambiguous strands can be drawn together to form a balanced understanding of apparently conflicting determinants. Considerations of tradition and modernity, self-definition and the definition of others, reveal the group's strengths as well as weaknesses. As many historians have pointed out, the creation of colonial medical identities allowed the legitimisation of whiteness in historically non-white places.¹¹⁴ At the same time, identities were subtle local negotiations between colonised and coloniser: far more complex than just an imposition of arbitrary values from above.¹¹⁵

Adding to this rich intellectual tradition of secondary analysis are images derived from the sources themselves. Memoirs, diaries, even obituaries, relate familiar experiences from which ideas of shared collective perception and self-identity can be gleaned. Accounts of African careers show surprisingly uniform notions of colonial life in general and the colonial medical endeavour specifically. Such ideas were self-perpetuating. Narratives were written in such a way as to fulfil prescriptive

¹¹³ R Macleod, 'The 'Practical Man': Myth and Metaphor in Anglo-Australian Science', *Australian Cultural History*, 8, 1989, pp.24-49

¹¹⁴ W Anderson, *The Cultivation of Whiteness: Science, Health and Racial Destiny in Australia*, New York, 2003

¹¹⁵ Arnold, *Colonizing the Body*; Bell, *Frontiers of Medicine*; D Gordon, 'A Sword of Empire? Medicine and Colonialism at King William's Town, Xhosaland, 1856-91' in Sutphen and Andrews (eds.), *Medicine and Colonial Identity*, pp.41-60

expectations of what being a good colonial entailed.¹¹⁶ This was not merely mythmaking; certain motifs were repeatedly drawn upon because there were precisely what a reading public would want to hear. Particular images were so intimately associated with colonial life that they were regarded as imperative to the construction of an interesting account.¹¹⁷ Of course, not all colonial accounts consciously followed a script, but most emphasised certain aspects over others and used metaphors evoking an imagined idea of Africa.¹¹⁸ This concept was as much about the realities of geography as about the identity that the British were creating for themselves in Africa. Moreover, the shared themes of colonial careers were vividly realistic descriptions of communal experiences that were central to creating certain attitudes. Colonial doctors wrote about similar things because they experienced similar things and because they came from shared backgrounds.

Just as the narrative evidence reveals shared leitmotifs, the prosopographical evidence points to broad similarities in the type of recruit. Most doctors, if they survived a year, stayed in East Africa for at least ten years; many for even longer.¹¹⁹ Furthermore, many retired Colonial MOs returned to the African continent, not just because they had formed important local relationships and had become accustomed to certain African lifestyles, but because they had formed emotional attachments to the countries in which they had spent much of their professional lives.¹²⁰ Most importantly, ex-colonials remained connected to their peer group through colonial associations based in the United Kingdom such as the Corona Club (disbanded 1999) or the Overseas Pensioners Association (still active). It was common for colonial doctors, like members of the other Colonial Services, to record that the African experience had somehow infused their being. The colonial identity clearly went

¹¹⁶ This idea can be related to ideas expounded by Sahlins over the 'performance' of culture in which we all participate. Sahlins, *Culture in Practice*

¹¹⁷ R Macleod, 'Colonial Doctors and National Myths: On Telling Lives in Australian Medical Biography' in Sutphen and Andrews (eds.), *Medicine and Colonial Identity*, pp.125–42

¹¹⁸ RB Inden, *Imagining India*, 2000 [1990]; For filmed images see K Dunn, 'Lights...Camera...Africa: Images of Africa and Africans in Western Popular Films of the 1930s', *ASR*, 39, 1996, pp. 149–75

¹¹⁹ Some were encouraged to become settlers such as the Soldier Settlement Scheme in Kenya after World War One, which was extended to provide land grants to ex-Colonial Officers. Kennedy, *Islands of White*, pp.72–3

¹²⁰ "So Africa grips us, through one interest or another, binding us to her as in the deep forests lianas bind the forest trees". M Trowell, *African Tapestry*, 1957, p.18

beyond the mere length of time in post. It became imbued with nostalgic overtones, especially after the collapse of the British African Empire during the 1960s.¹²¹

* * *

This work profiles Colonial MOs working in East Africa. It will see what type of candidate entered the Service, suggest their motives and examine their subsequent experiences. While the trends and tables present an accurate profile of colonial medical personnel, other claims, especially surrounding the ways doctors looked at their work and career, are more impressionistic. In describing group motivations and identities there is always the danger of clouding the subtleties and idiosyncrasies of individual incentives, opinions and sometimes facts in misleading generalities. The findings presented within these following pages should therefore not be taken as definitively representative of unanimous and collective opinion, but rather to reflect one cultural historical aspect of a wider story. Regrettably, but typically, most available information comes from the elites who left evidence in the form of memoirs or had obituaries written of them.¹²² Some of the longest-serving officers left almost no historical traces: often nothing more than a name, departmental position and sometimes date of appointment within the *Colonial Office Lists*. These doctors, who represented the regular public face of health care, would have served thousands of people but left no personal papers or memoirs.

A potential pitfall of a study of this type is that it examines the work and roles of a group who can, without much difficulty, be retrospectively identified as embodying the racist ideologies and presumptions typical of the colonial era. The modern-day postcolonial spirit naturally influences approaches within history and prevailing attitudes often emphasise the Service's negative, oppressive, or at the very least, exclusionary, aspects. The ideal balance is a challenging one to achieve: without

¹²¹ For a tremendously important resource see the oral history archive at the British Empire and Commonwealth Museum, Bristol. This is sure-fire testament that ex-colonials relished talking about their lives and evidences the similarities in their experiences. For details of the holdings (but regrettably no MOs from the period and area covered by this study) see, British Empire and Commonwealth Museum, *Voices and Echoes: A Catalogue of Oral History Holdings of the British Empire and Commonwealth Museum*, Bristol, 1999 [1998]; See also the ODRP project at Rhodes House, Oxford.

¹²² 107 obituaries have been located (Appendix 4). These sources should also be recognised as subjective.

condoning colonialism and all its attendant baggage, to make fair assessment of the work of those that went abroad in the service of Empire. This study attempts to represent a body of professionals and makes no judgments over whether their attitudes, opinions and preconceptions were intrinsically 'right' or 'wrong'.

This is a history of how and why Colonial Medical Service doctors were recruited and examines their experiences once posted to East Africa. A colonial medical identity is recognised as existing, but that is far from presuming that all officers were engaged in the same duties or felt the same about their careers. There is no necessary contradiction in recognising overriding group identifiers, operating within a common conceptual framework, while simultaneously appreciating the divergent nature of individual lives.

2. Joining the Colonial Medical Service

“We want good men, but not Oslers or Treves”.¹

This chapter describes the bureaucratic processes of recruitment to the Colonial Service in general and the Colonial Medical Service specifically. Its purpose is to explain the administrative context of this first stage of the colonial medical experience by revealing the process that applicants had to undergo and the terms under which they were employed. This will provide a framework for subsequent discussion of the reasons for joining the Service (Chapter 3), the ‘reality’ of colonial medical experience (Chapter 4) and the shared experiences, inherent in the Medical Service identity (Chapter 5).

In the first section (2.1), the relative status of the Colonial Service as a professional choice is described; especially the way interested people could obtain information about possible vacancies and the CO managed the recruitment process. General application and selection systems and criteria were routinely applied to all branches of the Colonial Service, so it is important to understand this common context to grasp the fundamental tenets of medical recruitment. The way medical recruitment differed from this broad model is analysed in more detail in section 2.2. The official expressions of policy are then supplemented through an examination of the rather more subjective criteria of selection employed by the CO (2.3). Naturally, these criteria directly impacted upon the type of person who was chosen and are of central importance to later analysis of personnel profiles. In many ways the ideal ‘type’ looked for by recruiters can be seen (unsurprisingly) to mirror directly the standards of the first Director of Recruitment, Ralph Furse (1887–1973; in office 1910–48), as well as the prevailing values of society at large. This chapter argues that long after the system of influence for securing colonial appointments (the patronage system) was officially abolished in 1930, an informal network still operated aimed at recruiting socially, ideologically and physically, the ‘right’ sort of officer.

¹ RHL/MSS.Brit.Emp.s.415, Furse Papers, Memorandum: Furse to Lord Milner, 18/06/1918

In section 2.4 medical recruitment changes throughout the period are examined and quantified, identifying periods of pressure as well as periods of relative ease. This analysis reveals that opportunities of entering the medical service were not constant throughout the period and that the Colonial Medical Service rose and fell in popularity; though not necessarily in accordance with other broader economic fluctuations, as might be expected. Lastly (2.5), the rules and regulations under which the Colonial Medical Service doctors were employed in East Africa are examined in order to frame subsequent consideration of the career's (perceived and real) advantages and disadvantages. This encompasses the official constraints on practice that doctors in the field needed to negotiate both individually and collectively.

2.1 Recruitment into the Colonial Service

The Colonial Service benefited and suffered from its prestigious connection with other Government Services. On one hand, its reputation was inextricably bound to the high-status perceptions of the Foreign Service, the Home Office Service and the Indian Civil Service as worthy and highly respected career choices for young graduates. On the other hand, it was commonly regarded, particularly until the 1930s, as a somewhat poor relation in terms of status. Much of this 'bad press' was because it was a comparatively new public service lacking a centralised bureaucracy. Before 1905, when the responsibility for many Colonial territories was moved from the Foreign Office to the CO, the Colonial Empire's staff were decentralised and non-uniform; in the candid words of one medical observer it was, administratively speaking, "in a muddle".²

Added to these organisational problems was the small size of the Service. Recruitment opportunities were fairly rare and, when vacancies did occur, the Colonial Officers who held them considered them to be poorly paid. Furthermore, selection was conducted by interview, with its associations with patronage and informal influence, rather than through the competitive examinations instituted for entry into the Indian or Home Services. This made the Colonial Services relatively

² This comment is specifically about the Medical Service, although the structural criticisms could have been applied to any branch of the Service. S Squire Sprigge, *Medicine and the Public*, 1905, p.110

unattractive to first-rate candidates fresh out of university. Without overplaying this point — the career still held many prestigious nuances through its association with the government and politics — the image of a “small and haphazard” Service, especially during the first twenty five years of the twentieth century; was pervasive enough to cause governmental concern.³

A markedly defined hierarchy of eminence existed among public service careers abroad. The most elite services included the Sudan Political Service and the Indian Civil Service and the man in charge of Colonial Service recruitment, (later Sir) Ralph Furse, spent most of his professional energies in nurturing a similar “*corps d’élite*” in the Colonial Service.⁴ Furse’s CO career spanned more than three decades (1910–1948) and he was indubitably the single most important figure in terms of raising the profile of, and organising, Colonial Service recruitment. He was himself a patronage appointment — his own job interview had only lasted ten minutes — a stalwart Tory who had attended public school and then read classics for a third-class degree at Oxford.⁵ In many ways his values represented the most traditional and the conservative elements of society and they can be seen to be both the symptom and the cause of the prevailing Colonial Service ethos.⁶ His most notable achievement was the Warren Fisher Committee (1930) which was called for by the then Secretary of State Leo Amery “[l]argely as a result of Furse’s representations” at the end of the 1920s.⁷ This important Committee examined the question of Colonial Service recruitment in detail with an aim of streamlining and centralising the previously cumbersome procedures. It marked the beginning of bureaucratic modernisation within Colonial Service recruitment; unifying all the various branches into vocational groups, with more standardised conditions of service and more

³ W Ormsby-Gore, ‘Foreword’ in C Jeffries, *The Colonial Empire and its Civil Service*, Cambridge, 1938, pp.vii–xi, p.vii

⁴ R Furse, *Aucuparius: Recollections of a Recruiting Officer*, Oxford, 1962, p.221 He also went on to say “I wanted it [the Colonial Service] to take a place comparable to the Indian Civil Service in the public imagination”. *Ibid.*, p.222

⁵ Perhaps this unhappy university result influenced Furse’s continued stress on the importance of values imbibed at school. *Ibid.*, pp.9–10.

⁶ R Heussler, *Yesterday’s Rulers: The Making of the British Colonial Service*, New York, 1963, p.14

⁷ ‘Ralph Furse’, *The Times*, 05/10/1973, p.21; ‘Sir Ralph Dolignon Furse’ Lord Blake and CS Nicholls (eds.), *Dictionary of National Biography 1971–80*, Oxford, 1986, pp.327–8

opportunities for inter-territorial transfers. The hope was that the Service would acquire a more international and unified ethos. As a direct result of the Committee all appointments were overseen by a central Appointments Board, which was part of a newly established Personnel Division. Furse handled recruitment and training, and Charles Jeffries (1896–1972) was in charge of conditions of service and promotions.⁸

Before these reforms were implemented, the system of recruitment was based on patronage — a selection system that had been in existence since the beginning of the Colonial Service in the 1830s. Candidates were selected through a system of ‘introductions’, usually by a friend or relative who was known to the CO; any candidate who was then deemed suitable was subsequently ‘invited’ to apply for a position.⁹ By the inter-war period, however, when Colonial Service recruitment problems necessitated widening the recruitment base to encourage more middle-class candidates, patronage became recast as increasingly old fashioned, unfair and untenable. By the 1920s, a warning against any attempt to exert personal influence over any part of the selection procedure was routinely published in the official recruitment literature, advising that any evidence of a candidate interfering with a selection decision may “seriously prejudice his chances of success”.¹⁰ Although CO rhetoric increasingly distanced itself from patronage the system was not formally abolished until the implementation of the recommendations of the Warren Fisher Committee. Despite attempts by Furse to minimise his department’s associations with patronage, the Committee felt obliged to conclude that up until that point the system of Colonial Service recruitment had been “at any rate in theory, a system of patronage”.¹¹ It is easy to extend this argument even further. Furse himself reminisced in his autobiography (1962) that Colonial Service recruitment was run primarily through a system of “personal contacts” throughout his tenure, which

⁸ Furse, *Aucuparius*, p.240

⁹ For a nice description of how the system worked see P Mitchell, ‘Forty Years Back’ in A Kirk-Greene, *Glimpses of Empire: A Corona Anthology*, 2001, pp.278–80, p.278

¹⁰ *Miscellaneous No.99: Colonial Medical Appointments*, 1921 [29th Ed.], p.4. This information was circulated in the Colonies and had been stressed since the beginnings of British Colonial Rule in Africa. PRO/CO/612/2 Circular Despatch: ‘On the Use of Influence Among Government Officers’, *UP Gov.Gaz.*, 31/07/1911, pp.301–2; PRO/CO/542/5 Chamberlain, published letter: ‘The Issue of Colonial Officers’ Promotion by Irregular Means’, *EAP Gov.Gaz.*, 15/08/1911, pp.373–4 [a reiteration of an original despatch, 18/12/1897]

¹¹ Report of the Warren Fisher Committee, 1931 quoted in Furse, *Aucuparius*, p.240

ended in 1948 (although he remained as an adviser until 1950).¹² Furse actively controlled the markets in which the Service career was promoted placed official liaison officers in favoured universities. He organised visits to suitable (i.e. public and sometimes top grammar) schools to stimulate recruitment, rather than push towards entirely open and meritocratic selection processes for all, regardless of educational background or social standing.

In accordance with this tradition, the Colonial Service rarely advertised positions; indeed it was thought that to do so would cheapen its appearance. The Service relied on its reputation and on an informal network of recommendations and hearsay, to stimulate interest.¹³ There were several ways, however, that interested people could obtain information about the Colonial Service. During the early years of the twentieth century, the annually published *Colonial Office List* was an obvious first port of call for official information on the British colonies. As well as including detailed historical and statistical information on each of the territories to allow prospective candidates to 'get a feel' for the job, it published related papers presented to parliament and information about major, historical and current, colonial developments. Each volume included a copy of the most recent colonial regulations (also obtainable as a separate publication) as well as a section offering information to prospective candidates: 'Information as to Colonial Appointments'.

A prospective applicant could apply for further information from the CO, who issued a series of slim pamphlets, outlining extended guidelines for appointment.¹⁴ Many of the original versions of this literature are extremely rare and difficult to locate, but there is evidence that this modest marketing exercise was in

¹² *Ibid.*, p.224. Furthermore, after Furse's retirement, his brother-in-law Francis Newbolt succeeded, continuing his policies until 1954.

¹³ "Anything in the nature of recruiting or 'touting' for men must be avoided...it is an honour to be chosen" RHL/MSS.Brit.Emp.s.415, Furse Papers, Furse, 'Confidential No.38: Recruitment and Training of Colonial Civil Servants', CO Conference, 1927, p. 13. "[A]dvertisement in the press, save in the case of an exceptionally attractive or unusual vacancy, should only be used as a last resort. It would normally be guaranteed to attract a mass of rubbish, and so few nuggets as to make sifting the scrap-heap a waste of time." Furse, *Aucuparius*, p.224

¹⁴ The earliest included *Miscellaneous No.117: Legal Appointments*; *Miscellaneous No.115: Colonial Police Appointments*; *Eastern No.85: Hong Kong, Straits Settlements and the Federated Malay States Police Probationers*; *Miscellaneous No.99: African (West) No.678: West African Medical Staff*; *African No.775: Regulations for the Employment of Officers in the East Africa, Uganda and Somaliland Protectorates*; *African No.839: Pensions and Gratuities (East Africa)*; *African (West) No.748 West African Pensions Laws*

existence as early as the last decade of the nineteenth century.¹⁵ Interestingly, the titles of these pamphlets reveal that, even during the first few years of the twentieth century when Britain was still coming to grips with her newly acquired territories, there was a sense of the Colonial Empire staff being managed in broad vocational and regional groupings. Geographically, the colonially administered Empire was seen as being divided into (in the loosely accepted order of superiority) the Eastern, West African, East African, West Indian and Western Pacific Services.¹⁶

The economic arrangement of Empire meant that territorial issues of economic feasibility were constantly over-riding any sense of geographic and vocational identity. The colonial personnel of each territory were funded internally from that government's funds; recommendations over staffing needs were therefore usually made from within each colony. Governors would fill out a vacancy request form and through this would inform the Secretary of State of the staffing needs of the country for which they were responsible.¹⁷ In the early formative years, Governors would often recommend the establishment of new positions as well as requesting candidates for current ones. After Colonial Service unification frequently revised staffing schedules were created that listed the names of all staff positions in each dependency. Staffing needs were, technically at least, tied to the filling and refilling of these core positions.¹⁸ In principle, the Secretary of State had to approve all appointments, except those at the very lowest end of the Colonial Service where candidates were recruited locally and were hired on salaries of less than one hundred pounds a year.¹⁹ In practice most lower (i.e. almost exclusively non-European)

¹⁵ The earliest complete example I have found is *Miscellaneous No.99*, 1921. This was the 29th edition, so presuming it was edited and updated yearly, this indicates that these memoranda had been produced since the early 1890s. The *CO List* of 1899 provides earliest mention of a separate memorandum for medical appointments available on request from the Assistant Private Secretary (i.e. the Patronage Secretary) at the CO.

¹⁶ The Eastern cadetships were pre-eminent because they were separately recruited with their own entrance examinations. Mitchell, 'Forty Years Back', p.278

¹⁷ For a (medical) example of the form see PRO/CO/822/23/3 Vacancy Form, Tanganyika Territory, 27/08/1930

¹⁸ These 'Schedules of Offices' were published at the beginning of the 'Green Books', the first of which was to appear for the Colonial Medical Service in 1936. Even though a position may only be listed once, this did not mean that several people could not be appointed to that position. Eg, *Colonial Medical Service List*, 1936, pp.2-8; for the policy on using these schedules as guides to appointments see PRO/CO/850/106/5 Circular Dispatch: W Ormsby-Gore to all Colonies and Protectorates, 05/05/1937

¹⁹ 'Information as to Colonial Appointments', *CO List*, 1899, pp.346-8, p.346

appointments made by the Governor were merely rubber-stamped by the Secretary of State. In exceptional instances, especially in times of severe staff shortages, local European candidates could be appointed on a temporary basis by the Governor of the Colony or Protectorate. These temporary appointments were, however, then to be subsequently applied for via the usual application form and confirmed centrally by the Secretary of State for “fuller investigation than may be possible to the Governor” before the position could be made permanent.²⁰ Europeans were seldom appointed in this way: it was considered more desirable that local applicants return to the United Kingdom and apply through the normal procedures instituted in London.²¹

Selections to the CAS and to Services where specialist professional qualifications were required (such as the Medical, Legal, Accounting or Scientific Services) were made through application and then interview through the CO in London. For posts in Ceylon, Hong Kong, the Straits Settlements and the Federated Malay Straits, cadetships offering on-the-job training for civil administrative posts within the colonies were available to young British subjects.²²

Applicants not wishing to apply through one of the cadetship schemes — including all administrative and medical appointments — had to submit an application form (P1), obtainable from the CO, outlining their career history and qualifications as well as their preferences for colonial employment.²³ They also had to submit six copies of testimonials covering all stages of their educational and professional career as well as names of at least two referees who could vouch for their “character and capacity”.²⁴ At this stage the CO would often make “further

²⁰ PRO/CO/877/3/37175 Circular: ‘Recommendation of Local Candidates by East African and Northern Rhodesian Governments’, 01/08/1924

²¹ Eg, the advice of the Claude Chevallier, acting PMO Kenya, to an interested local European applicant, Dr Wand, who found himself in East Africa through his former RAMC engagement. KNA/MOH/1/9940 Chevallier to Wand, 27/09/1920

²² A cadetship was won through a competitive examination, which, until the mid 1920s was the same as that taken by Home and ICS candidates. The competitive examination for the police forces of Ceylon, Malaya and Hong Kong were discarded in 1924 (in favour of a literacy test and then personal selection); in 1927 the customs service of Malaya also joined this group. Furse, *Aucuparius*, p. 147

²³ ‘P’ for Patronage and then later (conveniently) for Personnel.

²⁴ This phrase was retained in recruitment literature throughout the period. PRO/CO/877/15/17 Colonial Service Application [Form] (P1)[n.d. c. 1930]; ‘Information as to Colonial Appointments’, CO List, 1899, p.348; *Colonial Service Recruitment No.3: Information Regarding the Colonial Medical Service*, 1935, p.6

enquiries” as well as obtaining references.²⁵ If assessed as suitable, candidates were called for an interview, usually conducted by one of the Assistant Private Secretaries (later, a member of the recruitment department), but sometimes, in the case of specialist appointments, by regularly meeting panels of relevant subject experts.²⁶ On successfully passing this stage of the application procedure, the candidate’s name was then put onto the colonial vacancy list, along with the class of employment for which they were thought suitable. The CO was at pains to stress, however, that “no definite prospect whatever can be held out” that a place on this list would lead to the offer of a colonial posting.²⁷ Candidates were instead encouraged to pursue other employment in the knowledge that, were they fortunate enough to be offered a post, the CO would contact them and allow time for them to work out their notice. This system which could not guarantee a position even after selection by interview further damaged the career’s reputation, in that it failed to hook good candidates before they were offered alternative employment elsewhere.

In the period before 1930 the entire application process was overseen by the Assistant Private Secretaries (Appointments), of which there were two after 1910. They were directly responsible to the Secretary of State and, theoretically if not actually, presented all recommendations for selection to him.²⁸ After 1930 this same recruitment procedure was overseen by the Director of Recruitment (Colonial Service), who chaired the monthly meetings of the Colonial Service Appointments Board.²⁹ It was during this period, that stronger links were forged with the British Universities as part of Furse’s project to improve the profile of the Colonial Service

²⁵ Furse, *Aucuparius*, p.230

²⁶ *Miscellaneous No.99*, 1921, p.4; *Colonial Service Recruitment No.3*, p.7

²⁷ ‘Information as to Colonial Appointments’, *CO List*, 1899, p.348; This is reiterated, in slightly different words, in the later period: *Colonial Service Recruitment No.3*, p.7

²⁸ It was clearly an informal policy that the Secretary of State did not always confirm all levels of Colonial Service appointment. Even in the 1920s Furse described Churchill as having been incredibly hands-off. To the extent that, once broadly satisfied with Colonial Service recruitment, Churchill declared that submissions no longer needed his confirmatory signature. Furse, while grateful for the confidence put in him, felt that this would have looked unprofessional, and came to an arrangement with Private Secretary, Edward Marsh that submissions would continue to be made and come back autographed (even though Marsh was faking Churchill’s signature). Furse, *Aucuparius*, p.83

²⁹ The Appointments Board interviewed all candidates to the CAS, but “expert advisors” conducted interviews for the specialist and technical services. Their recommendations were passed on to the Appointments Board for approval. PRO/CO/877/8/2, ‘Colonial Service Appointments Board: Composition, Function and Methods of Procedure’, [n.d.c.1931]

career among graduates.³⁰ One practical result was the reduction in 1925 of the minimum entry age for all candidates destined for tropical Africa from twenty two to twenty one and a half; a small change which meant that graduates could start their colonial career straight, or very soon, after finishing university.³¹ Another change introduced later in the 1930s was the imposition of definite deadlines upon the application procedure for many branches of the Service, thereby aligning start dates with the university calendar. Vacancies for the CAS, for example, were to be applied for between 1st January and 30th April, with selections usually made after the academic year had ended in July or August. It was hoped that the opportunity of securing a career almost immediately after graduation would encourage applications.³² From an early date, Furse encouraged the active involvement of university-based appointments committees in putting forward suitable candidates. This was part of a programme promoting the Colonial Service throughout the universities, particularly Furse's approved universities: Oxford, Cambridge and London.³³ By 1936 appointments committees based at these universities were nominated within official appointments information as the most useful first port of call for graduates, even before they contacted the Director of Recruitment.³⁴

Although candidates from the Dominions had always been theoretically eligible to take up Colonial Service positions, feelers were put out during the 1920s to make the career path more widely advertised and accessible. Previously, potential entrants from the self-governing Dominions had to conduct their applications long-distance and could have been interviewed only if they had happened to be in England

³⁰ Furse, *Aucuparius*, p.224; PRO/CO/877/4/4 'London University Appointments Board: General Correspondence', 1927-9

³¹ PRO/CO/877/3/57672 Memorandum: 'Question of Minimum Age Limits for Candidates for Appointment to Tropical Africa', 06/04/1925

³² *Colonial Service Recruitment No.1: The Colonial Service, General Information Regarding Colonial Appointments*, 1936, p.8, pp.12-13

³³ Although in the late 1920s and early 1930s Major Hutchinson went on a tour of certain provincial universities and medical schools to publicise the Colonial Service, these less established universities were never given as much attention as the core three mentioned above. PRO/CO/877/7/8 'Visit by Major Hutchinson to Scottish Universities and to Liverpool University to Encourage Recruits', 02/1930. In 1931 Hutchinson also toured "certain provincial universities" in the English Midlands and the North. PRO/CO/877/8/18 Furse, 'Progress Report for the Appointments Department, No.1', 01/07/1931, p.6

³⁴ *Colonial Service Recruitment No.1*, p.28

or had travelled there especially.³⁵ Naturally, physical distance combined with an ever-growing sense of independence from the mother country meant that applications from this group were rare, not least because of the difficulty of quickly obtaining any information. To improve things Furse appointed contacts within universities in the Dominions. These liaison officers promoted the career and put forward suitable candidates to a central appointments board rather than having to send them to London. The first of these was set up in Canada in 1922 (operational in 1923). Others soon followed in Australia and New Zealand. Notably (and perhaps reflecting a concern to keep Colonial Service management fundamentally British), all recommendations of the Appointments Boards were still formally subject to the approval of the Secretary of State in London.³⁶

Gradually, formal courses were established to give special training for those selected for colonial appointments, usually to be attended before the official start of the contract. Specific tropical medical training was given for Colonial MOs from 1899, a decade before a specialised training course was offered for entrants to the CAS.³⁷ Specialised courses and scholarship schemes were later set up for some other services; schemes initiated by Furse as part of his effort to revive the profile and value of entrance to the Colonial Service.³⁸

General Entry Criteria

Certain restrictions upon entrance into the Colonial Service were enforced routinely. First and foremost candidates had to be naturalised British citizens, providing proof of their status through submitting their birth certificate (or a certified copy) early on

³⁵ PRO/CO/877/1/18180 'Openings for University men in the Colonies', 13/04/1921; See also A Kirk-Greene, 'Taking Canada into Partnership in the 'White Man's Burden': The British Colonial Service and the Dominions Selection Scheme of 1923', *CJAS*, 15, 1981, pp.33-54

³⁶ PRO/CO/877/2/38125 'Canadian University Candidates, Central Dominion Selection Committee', 08/1922

³⁷ This was the Tropical African Services Course, held initially at the Imperial Institute, London and, from 1926, at Oxford and Cambridge. Furse, *Aucuparius*, pp.151-2

³⁸ For example, a Forestry Course (1925), Colonial Agricultural Scholarships (1925) and Veterinary Scholarships (1929); A Kirk-Greene, *On Crown Service: A History of HM Colonial and Overseas Civil Services, 1837-1997*, 1999, pp.27-8

in the application procedure.³⁹ Exceptionally, some lower level vacancies were filled locally, by non-British candidates. MO positions in the West Indies, or some administrative positions in Malta, were open to non-Europeans, but the candidates had to have received all or part of their education in Britain.⁴⁰

The minimum age limit for most posts was 22.⁴¹ A university degree was virtually essential.⁴² After World War One, it became obligatory for all applicants to have served, providing they were of suitable age, in the war effort, as it was not thought appropriate that someone who had not been able to serve their country in a military capacity should do so in a civil one.⁴³ Although there was never an explicit ban on appointing women to the Colonial Service, most appointments throughout the period were of men. Women were increasingly considered as potential applicants as time progressed, but posts for which they could be considered were generally limited to fields that were considered specific to their gender, such as education, secretarial work, nursing and child health.⁴⁴ In the early years the CO specified the undesirability of appointing married men to the Colonial Service. This was modified in 1920 to a statement that although married candidates had to obtain special permission from the Secretary of State if they wished to take their wife with them,

³⁹ Although this was not stipulated in the CO medical recruitment pamphlets until the 1931 edition, it was mentioned as early 1920 in 'Information as to Colonial Appointments', *CO List*, 1920, pp.552–62, p.560. Practically all 'policy-forming' positions in the British Colonial Service were held by whites, contrasted with the more liberal French and Dutch Colonial Service policies see LA Mills, 'Methods of Appointment and Training in the British and Dutch Colonial Civil Service', *APSR*, 33, 1939, pp.465–72, p.466

⁴⁰ In 1930 it was declared that these locally recruited medical candidates from the West Indies no longer had to submit their applications through the CO, but could submit direct to the colony in which they wished to serve. PRO/CO/877/7/13 Circular: to Governors of Bahamas, Barbados, Jamaica, Trinidad, Windward Islands, Bermuda and British Guiana, 18/04/1931

⁴¹ Although some police and customs appointments were open to school-leavers and could be taken as young as 19 and, as previously mentioned, the entrance age to the CAS was lowered to 21 ½

⁴² "[A] University degree is an advantage in nearly all cases, especially if taken with honours, and in many instances...is essential", *Colonial Service Recruitment No.1*, p.11

⁴³ 'Information as to Colonial Appointments', *CO List*, 1920, p.552; This remained a part of the published guidelines until 1931, *Colonial Service Recruitment No.3A: The Colonial Service. Information for the use of Candidates for Appointment to the Colonial Medical Service*, 1931, p.7

⁴⁴ This issue in regard to female doctors is addressed in section 4.4

particularly on a posting to tropical Africa, which was considered unsuitable for women.⁴⁵

Candidates could express a preference on place of posting, but the CO reserved the right to appoint people as staffing needs required. Some places were naturally considered more desirable than others. West Africa presented perhaps the most mixed bag. On one hand, the governance systems and bureaucratic structures were more established and organised because of the longer British presence in the region, yet on the other, it was the most dangerous place to go in terms of health. Because of this reputation, appointees in West Africa received a higher rate of pay than colleagues in the East of the continent. West African appointments also enjoyed many “special privileges in respect of leave, absence and pension...on account of the unhealthiness of the climate”.⁴⁶ However, once an officer had undertaken a posting in West Africa, it was made clear that a transfer was unlikely: Later editions of the ‘Information as to Colonial Appointments’ stipulated that “no applications for transfer can be entertained until an officer has served for five years in West Africa”.⁴⁷

The Colonial Service clearly experienced prestige problems in the period leading up to the First World War. In an attempt to amend this, Furse improved communications with the leading universities and created contacts in the Dominions to make the career more accessible to a broader range of people. Specialised training courses were initiated in an attempt to foster institutional identity early on and to provide specialist training relevant to the tropical world.

Throughout the period the Colonial Service remained true to its meritocratic principles: a tenured career path for gentlemen, to be entered at a junior level with fixed steps towards promotion. Although prominent outsiders were sometimes

⁴⁵ ‘Information as to Colonial Appointments’, *CO List*, 1920, p.560; Also PRO/CO/323/999/4 ‘Marriage Restrictions: Terms of Appointment for Colonial Service’, 1928

⁴⁶ ‘Information as to Colonial Appointments’, *CO List*, 1899, p.347

⁴⁷ ‘Information as to Colonial Appointments’, *CO List*, 1908, pp.443–6, p.445

appointed to the most prestigious positions, it was more common for officers to work their way up the Colonial Service career ladder.⁴⁸

Most strikingly, even after the setting up of the Colonial Service Appointments Board on the recommendation of the Warren Fisher Committee, many of the core mechanisms of application and appointment remained virtually unchanged. The most conspicuous shift was one of emphasis. Before 1930, discourses about the Colonial Service were very regional in their descriptions of the separate and individual public services; after the Warren Fisher Committee (and in accordance with its intention) stress was placed upon unifying factors rather than on any differences. This in turn had positive effects on the status of the career in the popular imagination. By 1939 the Colonial Service was presented as a single, integrated entity offering an attractive opportunity to work within one of its many unified branches in a stable, flexible, varied and rewarding career.

2.2 Recruitment into the Colonial Medical Service

Medical appointments were dealt with in detail within CO memoranda produced for the information of potential candidates and available upon request from the Assistant Private Secretary (Appointments), later the Director of Recruitment. Most relevant in terms of East African recruitment were *Miscellaneous No. 99: Medical Appointments in the Colonies (except West Africa)*; and *African (East) No.1103, Regulations for the East African Medical Service*. These were usually revised and updated annually, but less frequently during the 1930s. After 1930 all colonial memoranda were heavily revised and a new, simpler numbering system was introduced to reflect the clearer-cut, modern systems of the new Appointment's Branch. *Miscellaneous No.99* reappeared in 1931 as *Colonial Service Recruitment No.3A* [Later 3]: *The Colonial Service. Information for the use of Candidates for Appointment to the Colonial Medical Service*. The fundamental format was retained after Medical Service unification in 1934.⁴⁹

⁴⁸ Except when new medical departments were established. When Britain was awarded the mandate for Tanzanian rule the senior positions in its medical department were drawn from experienced personnel of other parts of Empire.

⁴⁹ *Colonial Service Recruitment No.3*

The Colonial Medical Service was promoted each September, in the educational number of the *BMJ*.⁵⁰ This consisted of an article explaining opportunities for, and types of, employment. In accordance with the CO preference not to advertise, it was only during times of recruitment shortage, as in the late 1930s, that further advertisements were placed in the *BMJ* and *Lancet*.⁵¹

From the mid-1920s, further interest in the Medical Service as a career was stimulated through promotional visits by CO employees to British medical schools, especially through contacts with the Deans, but also through lectures to medical students.⁵² One tactic was to invite officers to return to their former medical schools to give short lectures on their impressions of their colonial experiences.⁵³ The practice of “direct communication” with the medical schools was considered so successful, that in 1931 when it was suggested that liaison officers be appointed (as at Oxford and Cambridge Universities) this was deemed unnecessary.⁵⁴

From the beginning of the century until 1930 official publications emphasised the separate territorial medical staffs as distinct groups with their own rules and regulations. The official CO literature stressed that transfers between the geographical areas were usually only offered at senior levels. Two exceptions were the WAMS and the medical staff of the Straits Settlements and the Malay States. Both these had been traditionally presented as single, self-contained, Services with a higher level of regional integration that offered more systematic promotion schemes, regularised pay scales and opportunities for inter-territorial transfer within the group.⁵⁵ The WAMS, established as a single service in 1902, particularly was upheld, even in the earliest days of its existence, as the model Medical Service. “A properly

⁵⁰ Eg. (to show both ends of the period): ‘Medical Appointments in the Colonies’, *BMJ*, ii, 1905, pp.585–8; ‘Medical Practice Overseas’, *BMJ*, ii, 1939, pp.540–4

⁵¹ PRO/CO/850/71/9 ‘Draft Advertisement: His Majesty’s Colonial Medical Service’, 11/01/1936

⁵² A Balfour, ‘Vistas and Visions: Some Aspects of the Colonial Medical Services’, *GMJ*, 6, 1924, pp.353–74; AGH Smart, ‘An Impression of Life in the Colonial Medical Service’, *St. THG*, 37, 1939, pp.123–6

⁵³ PRO/CO/877/7/8 ‘Visit by Major Hutchinson’; PRO/CO/877/8/18 Furse, ‘Progress Report for the Appointments Department, No.1’, p.6

⁵⁴ Although it was agreed that liaison officers in London would be useful for other Service branches. PRO/CO/877/8/8 ‘Scheme for Liaison Between the Colonial Office and the Colleges of London University’, 1931

⁵⁵ *Miscellaneous No.99: Colonial Medical Appointments*, 1923 [31st Ed.], p.2

organized entity” that the other medical services could benefit from emulating.⁵⁶ Even though the EAMS was not formally run as one regional service until 1921, it had long been regarded in the colonial administrative mentality as a single entity. Early Colonial Service staff lists, for example, listed the Eastern African areas together as one unit, and officers saw themselves in terms of this regional identity.⁵⁷

Just as there was a hierarchy within the colonial civil services, there was one within the medical services, which, despite the necessary professional qualifications of their candidates, fell some way behind the prestigious civil services in terms of status. Heather Bell has persuasively argued for the pre-eminence of the Sudan Medical Service as the one offering the best terms and conditions of employment at the beginning of the twentieth century, as well as benefiting from its associations with its famously elite sister Service, the Sudan Political Service.⁵⁸ The IMS came a close second. Although its reputation waned from the end of the nineteenth century the IMS had a long and distinguished history. It was difficult to get into, boasted several famous medical researchers, and enjoyed close ties with the prestigious Indian Civil Service.⁵⁹ The WAMS was the next most prestigious Service. Despite the unhealthiness of the West African climate the WAMS was a model of professional organisation with a relatively attractive remuneration package. The EAMS lagged behind as a fourth-class option.⁶⁰ The attraction of the Colonial Service career from the perspective of applicants will be discussed in Chapter 3. It is worth noting, however, that once an applicant had decided to apply for a Colonial Service position, rather than an Indian or Sudanese position (both which required taking a further examination), no guarantee could be given as to which region the applicant would be

⁵⁶ Squire Sprigge, *Medicine and the Public*, p.119

⁵⁷ FCO *East African Staff List*, 1914

⁵⁸ H Bell, *Frontiers of Medicine in the Anglo-Egyptian Sudan, 1899–1940*, Oxford, 1999, pp.39–40. Judging from statistics gathered in 1912, one estimate was that the Sudan Medical Service was “the most highly qualified Service in the world”, HC Squires, *The Sudan Medical Service, an Experiment in Social Medicine*, 1958, p.14

⁵⁹ Harrison has argued for the relative unpopularity of the IMS as a medical career choice before 1914, this was certainly true, but it still seems to have still been more prestigious than joining the Colonial Medical Service. M Harrison, *Public Health in British India: Anglo-Indian Preventative Medicine 1859–1914*, Cambridge, 1994, pp.27–35

⁶⁰ Unless the candidate was a woman doctor, in which case the best opportunities seemed to be in the Malayan Medical Service.

appointed. Applications for all territories were dealt with centrally and positions were filled as they came up in each country.⁶¹

It is difficult to assess how hard it was to get into the Colonial Medical Service, not least because the comparative numbers of enquiries, interviews and resulting appointments are unknown.⁶² There was certainly a perception that it was a good thing to try for if all other attempts to get work in Britain had failed (see Chapter 3), but recruitment uptake naturally varied depending on colonial staffing needs. Figures surviving for the five-year period 1924–9, suggest, “approximately 1 out of every 4 men, whose applications receive definite consideration, gets an appointment”.⁶³ A 1931 report stated: “In the last year or two the fact that the large majority of Medical Officers who make application are eventually appointed is an indication that there is now a general impression that the Service requires only well qualified and experienced officers”.⁶⁴ This period was a ‘boom’ period for both general Colonial Service and Colonial Medical Service recruitment, so it is hard to assess how this compares with depressed periods of staffing, when presumably it was easier to be appointed.

The general pattern of recruitment to the Colonial Medical Service followed that of the Colonial Service (see above). The candidate had to fill out a slightly different application form, a P1 (Med), rather than the standard P1. This contained additional questions about medical experience, details of prizes and distinctions, contributions to the medical literature, and a history of the candidate’s clinical appointments. It was also explicitly stipulated that one of the testimonials to be

⁶¹ Although naturally some doctors got their first choice, which they were allowed to specify on the P1(med). See R St-Johnston, *Strange Places and Strange Peoples or Life in the Colonial Service*, 1936, p.20

⁶² Furse’s autobiography tabulates the number of appointments which the Appointments Department dealt with between 1919–50, no expressions of interest are noted however, so although it can be seen how many applicants failed the medical examination or withdrew, summarily rejected applicants are not recorded. Furse, *Aucuparius*, Appendix 1

⁶³ RHL/MSS.Brit.Emp.s.415, Furse Papers, ‘Second Memorandum for the Warren Fisher Committee’, 01/1929

⁶⁴ RHL/MSS.Brit.Emp.s.415, Furse Papers, Memorandum: ‘On the Difficulty of Obtaining Candidates for the Colonial Medical Service’, 03/1931

supplied should be from the Dean of the medical school at which the candidate was educated.⁶⁵

Submission of colonial medical applications were originally called for in April of each year,⁶⁶ but by the early 1900s colonial appointments could be applied for at any time of the year and filled as circumstances required.⁶⁷ After the appointment of Sir Thomas Stanton as the first Chief Medical Adviser to the CO in 1926, suitable applications were vetted by his office, as well as being assessed through interview by the Colonial Medical Appointments Committee which met twice monthly.⁶⁸

The criteria for eligibility changed very little throughout the period. In the very early years it was specified that medical candidates should be “between the ages of 23 and 30 (25 and 32 in the case of West African appointments)”,⁶⁹ a rule that was later extended by increasing the upper limit for all Medical Service positions to thirty-five.⁷⁰ Later entry requirements were simply framed as “under 35 years of age” although “definite preference” was given to applicants under thirty.⁷¹ In East Africa there was a scheme whereby older, more experienced, candidates could apply to the Colonial Medical Service. These appointments were made for a fixed period of thirty months residential service and were paid at a rate of £700 per annum;⁷² they were offered only on a temporary basis and without any pension rights.⁷³ This scheme under which several of the MOs listed in the database were employed,⁷⁴ appears to

⁶⁵ KNA/MOH/3/246 P Ross, Application (P1 Med.), 1925; KNA/MOH/3/247 N MacLennan, Application (P1 Med.), 1925

⁶⁶ ‘Medical Appointments in the Colonies’, *BMJ*, i, 1891, p.770

⁶⁷ A policy that continued throughout the period. *Colonial Service Recruitment No.1*, p.8

⁶⁸ *African (East) No.1105: Information for the Use of Candidates to Appointments in the East African Medical Service*, 1925, p.8. There had been other earlier medical advisers to the CO, most famously Manson, but their appointment was not systematic until 1926 and slightly different in remit. Manson, as Consulting Physician for the CO had to conduct medical examinations of Service candidates as well as advise on policy.

⁶⁹ ‘Information as to Colonial Appointments’, *CO List*, 1899, p.347

⁷⁰ *Miscellaneous No.99*, 1921, p.3

⁷¹ *Colonial Service Recruitment No.3*, p.4

⁷² *Miscellaneous No.99*, 1921, p.5

⁷³ The appointee was not eligible for pension rights, but could claim a gratuity payment of £200 upon satisfactory completion of their engagement. *Ibid.*, p.3

⁷⁴ For example, Ernest Cooke (first employed aged 44); Geoffrey Gibbon (37); Frank de Smidt (37)

have been abolished by 1930.⁷⁵ Even including these older, temporary officers, the average age of entry into the Colonial Medical Service in East Africa from 1893–1939 was 30 years, quite young considering the figure is inflated by the higher ages of officers who entered the career on a temporary basis in their forties (see Chapter 5). As with the Colonial Service in general, another unwavering criterion was nationality: applicants to the Medical Service, in accordance were ineligible unless they provided proof of British citizenship.⁷⁶ For some services, including the WAMS, they had furthermore to be of European parentage on both sides. Although this specification was not formally stated for the EAMS until 1925,⁷⁷ the policy was effectively already in operation. It was always tacitly understood that CO officials were to refuse non-European candidates, although, in the interests of keeping the policy discrete they were “not to base their non-selection on racial grounds if candidates ask why they have not been selected”.⁷⁸ The application form requested not only the candidate’s birthplace and nationality, but also that of both parents. This information was plainly important, as the applicant’s referees were specifically asked to confirm (to the best of their knowledge) the nationality of not only the applicant but of their father too.⁷⁹

⁷⁵ No mention of this scheme is made in any of the recruitment literature after 1930.

⁷⁶ Although MOs did not need to be British born. Unlike the CAS where, although candidates need not be the children of British subjects (just European) on both sides, they needed to have been born in the UK. PRO/CO/877/4/12 ‘Appointment of Naturalised Colonial Service Subjects to the Colonial Service’, 16/08/1927

⁷⁷ At least, this is the first reference I have found. The East African, West African and Malayan Medical Services and the Eastern Police Services were the only ones in the Colonial Service to formally declare that racial origins would be a bar from appointment, until it was decided to change the wording in all recruitment memoranda in 1936. PRO/CO/877/13/22 ‘Eligibility of Indians for Colonial Service’, 1936; also see PRO/CO/537/910, ‘Admission of Asiatics to the Medical Service’, 1923; for information on the early position of the EAMS see *African (East) No.1105*, p.8

⁷⁸ PRO/CO/877/1/43122 Minutes: ‘Applications by Natives of India for Appointments in the Colonial Service’, 5th October 1921. Here one agenda item was a letter from PL Gupta (MB, ChB, DPH, FRCS) from Gwalier State, India (dated 17/08/1923). Gupta enquired whether there were likely to be any vacancies suitable for him either in the WAMS or EAMS. After discussion of the letter it was decided that “any such appointment would be undesirable” and, although Gupta should not be explicitly rejected on racial grounds, he was effectively ineligible because of them. It was subsequently confirmed that the CO policy of refusal, without making any open declarations over racial ineligibility, was the best one to continue pursuing at present.

⁷⁹ “Will you please state of what nationality you believe the applicant and his father respectively to be, and give the grounds on which you base this belief?” PRO/CO/877/15/17 Referees’ Statement, (P.7), [n.d., c.1937]

Ideally, and in contrast to the CAS, the Medical Service did not want candidates fresh out of university. It was preferable that candidates should have gained a couple of years' practical experience as house physicians or house surgeons.⁸⁰ This was justified in terms of the particularly trying experiences young doctors might meet in the colonies where: "a quite junior officer may often be placed in the position of having to deal with serious emergencies on his own responsibility, without the opportunity of consultation".⁸¹ By the 1930s more mature candidates with special skills were being actively sought: those who had public health experience or "special knowledge of anaesthetics, radiology, surgery, medicine, ophthalmology, gynaecology and midwifery, diseases of the ear, nose, and throat, venereal diseases, etc." ⁸²

As far as basic medical qualifications went, applicants were required to have passed their qualifying exams in both medicine and surgery.⁸³ This ordinarily meant the joint bachelor's degree awarded from a British university, or the double qualification (the conjoint) of the English, Irish or Scottish professional corporations.⁸⁴ Initially it was not specified that all candidates were to be registered in the United Kingdom under the terms of the 1858 Medical Act, so theoretically British subjects who had obtained their medical qualifications overseas, could apply. When the unified Colonial Medical Service was officially created in 1934, however, these rules tightened. It was decided that all new entrants must possess a British qualification, although those already in the Medical Service without qualifications registered in the United Kingdom would not be penalised.⁸⁵ No provision had been made for British or foreign subjects who had obtained medical qualifications abroad

⁸⁰ 'Information as to Colonial Appointments', *CO List*, 1899, p.347; [Cmd.939] *Report of the Departmental Committee Appointed by the Secretary of State for the Colonies to Enquire into the Colonial Medical Services*, 1920, p.4

⁸¹ Jeffries, *Colonial Empire*, p.150

⁸² *Colonial Service Recruitment No.3A*, p.6

⁸³ Since the 1885 Medical Amendment Act this was the minimum legal medical qualification. 'Information as to Colonial Appointments', *CO List*, 1899, p.347; *Miscellaneous No.99*, 1923, p.3

⁸⁴ Or the equivalent 'triple' from the Scottish Corporations: LRCS (Ed.), LRCP (Ed.) & LRFPS (Glas.)

⁸⁵ The EAMS and WAMS had stipulated this need to be registered in the UK for considerably longer, but until unification British doctors qualified in America, for example, could practice in the West Indies. Jeffries, *Colonial Empire*, pp.76-7; also see PRO/CO/850/12/13 'Circular Dispatch to Colonial Governors', 11/1932

until the [Medical Act] Amending Act of 1886, but reciprocity with all the larger Colonies (now Dominions) was established by 1902.⁸⁶

Finally, the medical positions were mostly available to men. This partly reflected the gender ratio output of medical schools, but also the perception that Africa, in particular, was largely unsuitable for women, especially for extended periods of time. In East Africa “Lady” or “Woman Medical Officer” was a specific job title requiring specific skills deemed appropriate for a woman to undertake. There were occasions, especially in the first thirty years of the period, when women were turned away from MO positions, not because they were under-qualified or unsuitable, but simply because the one post available to women was filled.⁸⁷ Such vacancies as were available to female MOs were usually confined to West Africa and Malaya and normally specified experience in child welfare work.⁸⁸

In accordance with broader CO policy, taking wives to tropical climates such as East Africa was discouraged, although it was allowed with the express permission of the Secretary of State. In the very early years it was stipulated that “preference will be given to unmarried candidates”,⁸⁹ but as this rule was later relaxed, to the point where it was expected that officers proceeding to East Africa could “usually take their wives with them on first appointment”.⁹⁰

⁸⁶ PRO/877/9/2 Memorandum: ‘Reciprocity with the British Dominions and with Foreign Countries’, 10/1930. The subject of medical reciprocity had a fraught history. Around end of 1928 an Act was passed in New Zealand “without notice to the General Medical Council” that New Zealand Medical Graduates would no longer be able to register their qualifications in the UK, effectively making them ineligible from that date to join the Colonial Medical Service. PRO/CO/877/6/8 Minute: ‘Central Board of Selection for New Zealand, Correspondence with AC Day [Dominions Liaison Officer]’, 22/01/1929. Relations with Canada’s provinces over issues of reciprocity had also been difficult, not least because there was no centralised medical authority there. PRO/CO/877/9/2 ‘Medical Reciprocity as between this Country and Canada’, 1931–2

⁸⁷ “Dr Isabel Hill MB, ChB Edin. Gave her P1 Med, Misc.99....Told her position—i.e. only one lady doctor’s post in Crown Cols. & that filled recently.” RH/MSS.Brit.Emp.r.21, CO Desk Diary, 1912, 31/01/1912

⁸⁸ ‘Information as to Colonial Appointments’, *Dominions and CO List*, 1939, pp.623–32, p.627

⁸⁹ ‘Information as to Colonial Appointments’, *CO List*, 1899, p.347

⁹⁰ *Colonial Service Recruitment No.3*, p.17. It is interesting, however, that into the 1930s vacancy requests still sometimes expressly stipulated a preference for medical candidates “unmarried if possible”, see PRO/822/23/3 Telegram: Governor of Tanganyika to Secretary of State, 25/03/1930

Interviews were held at the CO, usually, but not always, conducted by a specialist sub-committee.⁹¹ Colonial medical experiences varied: one eventual Principal Medical Officer (PMO) of Tanzania, John Owen Shircore, recalled a very unhurried, although formal interview, in the early 1900s:

Those were the days when candidates for such posts were expected to attend for interview in morning dress with top hat; the pace was appropriately more leisurely.⁹²

This formality, typical of the establishment, was reiterated in an unpublished memoir by Peter Clearkin (Sierra Leone, Kenya, and Uganda). He described his colonial medical interview in 1913:

[I was] conducted to a waiting room with half a dozen other applicants. Only one appeared to be a provincial like myself, the others, a superior class with a superior accent were dressed in the orthodox professional outfit of the day to wit, morning coat, striped trousers and appropriate accessories, plainly Londoners and very self-assured. They rather daunted me and I felt like slipping away from such an array of talent and elegance. However, I maintained a brave front emphasizing, if it were possible, my provincialness, attired as I was in a rough tweed suit and brogue shoes more suitable for the moors of Yorkshire and Durham than the pavements of Whitehall. My qualms were not diminished by conversation with my fellow provincial. He asked if it was the first time I had appeared before the selection Board. When he heard that it was and that I had been qualified less than a year he said I hadn't a hope but would be told to return when I had more experience; he, himself, had appeared before them twice without success but was hopeful this time.⁹³

Clearkin goes on to describe the questions asked by the "assortment of elderly bearded gentlemen" that constituted the interview panel: "[a] few enquiries were made about my amusements, hobbies, games etc." although he makes no mention of any questions relating to medical competence.⁹⁴

Once all the criteria had been met and an interview conducted there were still two further stages to be overcome an appointment was confirmed: the candidate had

⁹¹ *Miscellaneous No.99*, 1921, p.4; *Colonial Service Recruitment No.3*, p.7

⁹² 'John Shircore', *EAMJ*, 30, 1953, pp.355–6, p.355

⁹³ RHL/MSS.Brit.Emp.r.4, PA Clearkin, *Ramblings and Recollections of a Colonial Doctor 1913–58*, Book I, Durban, 1967, p.16

⁹⁴ *Ibid.*

to pass an examination in tropical medicine; and had to successfully undergo a physical examination. In accordance with the long held belief that diseases of tropical places required special medical expertise a qualification in tropical medicine was a crucial requirement for the Colonial Medical Service. One of the principal aims of the London School of Tropical Medicine (later the London School of Hygiene and Tropical Medicine (LSHTM)) was to provide a specialist education for MOs proceeding to the tropical world.⁹⁵ Even during the year of its opening, 1899, the 'Information as to Colonial Appointments' published in the *Colonial Office List* predicted that "all [Medical Service] candidates will eventually be required to undergo a course of training there after selection, and prior to taking up appointments".⁹⁶ As the School became established, the Diploma course it offered became a "required" qualification for all Colonial MOs taking up positions in Africa.⁹⁷ Although it was recognised (especially in times of staff shortages in the colonies) officers would sometimes have to proceed without attending the necessary course, permission to do this could only be obtained under the special directions of the Secretary of State. If granted, the MOs concerned were required to take the course during their first leave in the United Kingdom.⁹⁸

As the discipline of tropical medicine grew, it became possible to take the diploma course in several universities.⁹⁹ By 1939 three options were available: a five month course (The Diploma in Tropical Medicine and Hygiene) at the LSHTM, examined by the conjoint board of the Royal College of Physicians and Royal College of Physicians in London; two ten week courses (The Diploma in Tropical

⁹⁵ The Liverpool School of Hygiene and Tropical Medicine was to also play its role in training for incipient MOs, but this was not the primary impetus behind its establishment. Indeed, for a very short period (February 1898–August 1900), the Secretary of State stipulated that MOs should attend the London based course for at least two months, *even* if they had attended the Liverpool course. JWW Stephens, W Yorke B Blacklock, *Liverpool School of Tropical Medicine, Historical Record: 1898–1920*, Liverpool, 1920, p.12, p.20

⁹⁶ 'Information as to Colonial Appointments', *CO List*, 1899, p.347

⁹⁷ *Miscellaneous No.99*, 1921, p.5

⁹⁸ *Ibid.*

⁹⁹ From 1930 candidates recruited in Australia or New Zealand could take DTM (as well as DPH) at the Australian Institute of Tropical Medicine, (which moved in 1930 from Townsville to Sydney), rather than travel to England. PRO/CO/877/6/13 Furze, 'Report on the Arrangements for the Central Committee for the Appointment of Australian Graduates', 31/07/1929; see also PRO/CO/877/7/17, 'Establishment of a School of Tropical Medicine, Sydney', 1928–30

Medicine and the Diploma in Tropical Hygiene) offered by the Liverpool School of Tropical Medicine; and the eleven and ten week long 'primary' and 'secondary' courses leading to a Diploma in Tropical Medicine and Hygiene run by Edinburgh University.¹⁰⁰ Between 1904 and 1933 the University of Cambridge also ran a diploma course.¹⁰¹

Provided that the attendees passed the final examinations within the allotted time, took up their appointment as instructed, and did not resign within three years of assuming their post, the costs of attending these courses and sitting the examinations was borne by the colony to which the recruit was assigned.¹⁰² The course attendee was also eligible for a board and lodging allowance which, during the 1920s was £3 a week, with an additional "training allowance" of 5 shillings.¹⁰³ This figure was raised after unification to £25 a month and continued to be paid after the diploma course finished until the day before embarkation (when the officer would be eligible to receive half of his regular salary until the day of arrival at the port of destination).¹⁰⁴

The final hurdle the candidate had to overcome was the medical examination. This was a routine requirement from the start and was conducted by one of the consulting physicians to the CO. Between 1898 and 1919 this was Patrick Manson himself.¹⁰⁵ Later, when applications were allowed from candidates residing in a colony or dominion, it was performed by an MO appointed locally.¹⁰⁶

¹⁰⁰ *Miscellaneous No.407: Primary Courses of Instruction in Tropical Medicine and Hygiene for Officers Selected for Appointment to the Colonial Medical Service*, [6th Ed.], 1939, p.1

¹⁰¹ P Manson-Bahr, *History of the School of Tropical Medicine in London: 1899-1949*, 1956, p.51; L Wilkinson and A Hardy, *Prevention and Cure: The London School of Hygiene and Tropical Medicine A 20th Century Quest for Global Public Health*, 2001, p.150

¹⁰² *Miscellaneous No.407*, pp.1-2

¹⁰³ *African (East) No.1105*, p.6

¹⁰⁴ This was, of course, provided that the candidate embarked at the first available opportunity after the course had finished. *Colonial Service Recruitment No.3*, p.12; For passage conditions for East Africa see *African No.973: Regulations for the Employment of Officers in the East African Dependencies*, 1935, p.6

¹⁰⁵ LSHTM/GB0809/Manson/09 'Medical Examinations in Connection with the Colonies and Protectorates', 1898-1919 Indeed, Chernin has argued that this was Manson's principal role at the CO (i.e. more than policy making). E Chernin, 'Sir Patrick Manson: Physician to the Colonial Office, 1897-1912', *MH*, 36, 1992, pp.320-31

¹⁰⁶ *Colonial Service Recruitment No.3*, pp.7-8

The official guidelines under which Colonial MOs were recruited changed very little between the beginning of the twentieth century and the commencement of World War Two. MOs had to be young, Caucasian, physically fit, doubly qualified, have had a couple of years hospital experience, and have taken the Diploma in Tropical Medicine (later the DTM&H). But these were not the only criteria on which they were judged.

2.3 The Subjective Side to the Selection Process

The question of having the appropriate ‘character’ to be a good colonial servant was central to its recruitment procedure. The decision to select candidates through personal interviews was predicated around this. Although much-criticised, periodic attempts to dispense with the interview as a central tool of selection, were uniformly rejected.¹⁰⁷ Advocates of an examined entry system felt that it would improve the public status of the Colonial Service since a better quality of candidate would be attracted by a competitive examination. From the start, however, the CO upheld the view that the particular exigencies of the tropical world presented sufficient reason to assess candidates more on their character than any ability to pass an examination, especially when many had just been through university or medical school. The career was one in which “the variety of problems involved and the tact required are infinite, and hence it could hardly be made into a regular profession, with a rigid method of admission and promotion”.¹⁰⁸

Admittedly recruitment standards to the Colonial Medical Service, unlike some of the other services, could be measured more objectively because of the candidates’ professional qualifications. By implication, they relied less exclusively on the more nebulous concept of ‘character’ than appointments to the CAS, for example. Nevertheless, collective notions of character had a very significant part to

¹⁰⁷ G Evatt, ‘Notes on the Organisation of the Colonial Medical Service of the Empire’, *BMJ*, ii, 1896, pp.863–4, p.864; [Cmd.939] *Report of the Departmental Committee*, 1920, p.5; PRO/CO/877/6/10 ‘Recruitment of Candidates for the Home and Colonial Services: Proposal to Hold a Joint Competitive Examination’, 05/1929

¹⁰⁸ AL Lowell, *Colonial Civil Service: The Selection and Training of Colonial Officials in England, Holland, and France*, 1900, p.76. Lowell also pointed out that the examination system was open to all British Subjects and therefore had inadvertently allowed at times “a Sikh” and “a Mulatto” into the Eastern Cadetship scheme, *ibid.* p.74

play.¹⁰⁹ Every piece of information on the entrance procedure for the Colonial Service in general and the Colonial Medical Service in particular makes specific use of the word ‘character’ in its application information. Partly this is just the usual rhetoric of selection, but other evidence confirms that ‘character’ was indeed clearly defined personal qualification that had received much official consideration. An early Private Secretary, Edward Marsh, described the interview process: although qualifications were naturally taken into account, it was necessary to take careful note of “what we called the impression they made”.¹¹⁰ Furse himself was particularly eloquent on the need to select the ‘right sort’ of person for a colonial position. As officers were required to “represent the British Government personally” among the native races, he believed the “qualities of character, personality, tact and address” were of the utmost importance, and ones that he felt could only be ascertained through personal interview.¹¹¹ The overhauled recruitment guidelines that appeared after Medical Service unification could not have been more explicit: although practical and academic experiences were very important, equal, if not more, importance was placed upon character: “[S]uccess as a Medical Officer can only be achieved if his personality is such as to command the respect and trust of the native inhabitants of his Colony as well as the confidence of the local European community”.¹¹²

The assessment of character was sometimes undertaken before formal interview. The desk diaries (spanning the years 1899–1915) of the Assistant Private Secretary (Appointments), reveal that a snap decision was made when personal callers

¹⁰⁹ “We are naturally not insisting in quite such a high standard from a personal point of view with regard to medical appointments, where technical knowledge is the first consideration and where the supply of qualified candidates from this country is considerably below the number of vacancies which need filling”. PRO/CO/877/2/49403 Furse to FG Guggisberg [Governor, Gold Coast], 09/01/1923

¹¹⁰ E Marsh, *A Number of People*, 1939, pp.123–4

¹¹¹ PRO/CO/877/1/18180 Furse to A Hill [Secretary, Universities Bureau of the British Empire], ‘Openings for University Men in British Colonies’, 23/06/1921. Furthermore, this stress on character was one that was also made by Lord Lugard. Lugard specified in his famous *Dual Mandate in British Tropical Africa*, Hamden, CT, 1965, [5th Ed.], p.139 that the Colonial Service must exclude “as far as possible the ‘bounder’, the ‘prig’ and the ‘bookworm’” quoted in H Kuklick, *The Imperial Bureaucrat: The Colonial Administrative Service in the Gold Coast, 1920–1939*, Stanford, CA, 1979, p.20

¹¹² *Colonial Service Recruitment No.3*, p.10

came to the CO to enquire about potential employment.¹¹³ Someone deemed suitable was likely to leave with some promotional literature and an application form, while less suitable characters were dismissed with a polite excuse, if not a flat refusal. Kirk-Greene has shown how the “always subjective, often dismissive and frequently highly ‘politically incorrect’ process” which candidates underwent changed little between 1899 (the earliest Rhodes House patronage desk diary) and 1948 (the year of publication of the confidential CO *Appointments Handbook*).¹¹⁴ The same sort of instant character assessment was certainly applied to medical enquiries, irrespective of the fact that doctors were self-defining in terms of academic quality. Some of the comments about medical candidates in these early patronage diaries clearly refer to doctors who subsequently joined the EAMS. William Owen-Pritchard (Kenya and Tanzania) was described as “a very nice doctor”.¹¹⁵ An entry for Dr Lamborn may well refer to an early enquiry from William Lamborn (Tanzania), who although assessed as “not a gentleman” was nevertheless “extraordinarily cheerful & pleasing”.¹¹⁶ Anstruther Rendle, who went on to have a long colonial medical career (Uganda and Kenya) was judged, somewhat blandly, although by no means negatively, as a “rather nice man” who “would do well”, unlike his (also medically qualified) brother who accompanied him and was written off in the same note as “anaemic looking, much younger, rather colourless, [although] apparently inoffensive”.¹¹⁷ Two men who became heads of medical departments also had their preliminary interviews noted: John Owen Shircore (Tanzania) made a good impression being “gentle & well-liking”¹¹⁸ and if the Dr Milne interviewed in early 1909 is Arthur Milne who headed the Medical Department in Kenya, then the impression that he was “quite passable” was retrospectively an understatement.¹¹⁹

¹¹³ Although volumes for 1900, 1901 and 1913 are missing. A Kirk-Greene, ‘Not Quite a Gentleman’: The Desk Diaries of the Assistant Private Secretary (Appointments) to the Secretary of State for the Colonies 1899–1915’, *EHR*, 67, 2002, pp.622–33

¹¹⁴ *Ibid.*, p.626

¹¹⁵ RHL/Mss.Brit.Emp.r.21 Patronage Diary 1903, 15/01/1903

¹¹⁶ *Ibid.*, 1904, 30/12/1904

¹¹⁷ *Ibid.*, 1905, 08/08/1905

¹¹⁸ *Ibid.*, 1908, 06/03/1908

¹¹⁹ *Ibid.*, 1909, 29/01/1909

After application forms had been received — with a photograph to the back just to rule out any physical peculiarities — the next stage was the personal interview.¹²⁰ Furse, characteristically vocal over the intrinsic importance of finding the right “type of man”¹²¹ described his interview technique as follows:

We sat as far apart as we could so that a candidate who was being interviewed by one of us need not feel that he was being overheard by the others. At the same time we could often help each other by unobtrusively watching the other man’s candidate from a different angle. Interviewing boards normally sit on one side of a table with their victim on the other. By so doing they often miss significant details. For instance, a man’s face may not reveal that he is intensely nervous. But a twitching foot, or hands tightly clenched under the table, will tell you this, and you can make the necessary allowances or deductions, which are often important.¹²²

Clearly, a great deal rode on first impressions. Even as late as 1948 the confidential *Appointments Handbook* (made up of Ralph Furse’s recommendations, compiled by his deputy) stated that above all “intuition...must be...[the] guiding principle” in an interviewer’s technique. Body language was all-important: “You will have in mind the truism that weakness of various kinds may lurk in a flabby lip or in averted eyes, just as single mindedness and purpose are commonly reflected in a steady gaze and a firm set of mouth and jaw”.¹²³

Ideas of good character were further explored through the questions in the P.7 form. This was the form letter and statement issued by the CO to be completed by the referees named on the application form. Among the statements for the referee to complete were questions as to whether the candidate was “(a) honest? (b) of strictly sober and temperate habits? (c) industrious? (d) of sound moral character [and] (e) of active bodily habits?”¹²⁴ It was not enough for CO staff to judge a good character independently; they also relied on others to divulge character faults they might have

¹²⁰ C Jeffries, *Partners for Progress: The Men and Women of the Colonial Service*, 1949, p.82

¹²¹ Furse, *Aucuparius*, p.221

¹²² Furse, *Aucuparius*, pp.66–7

¹²³ F Newbolt, *Appointments Handbook*, 1948, extract ‘On the Process of Interviewing’ reproduced in Kirk-Greene, *On Crown Service*, pp. 191–6, p.196, p.193

¹²⁴ PRO/CO/877/15/17 Referees’ Statement, (P.7)

missed. The CO even had a secret list that rated the reliability of some referees over others.¹²⁵

Ideas of the right type can be roughly divided for into six groups of traits, all of which were necessarily interconnected and inseparable within any overall assessment: social qualifications, athleticism, mental stability, ability to rule, morality and self-reliance.

The pervasive idea that “the ethos of the ruling classes was the ethos of the Colonial Service”¹²⁶ had a long history stemming from the elite nature of early patronage appointments. This was largely true of all foreign Public Services, epitomised in the description of the Sudan as “that country of blacks ruled by blues”.¹²⁷ The class composition of the Colonial Medical Service will be discussed in a later chapter; what is important here are the impressionistic ideals of the model entrant. There was a clear sense that the right sort of candidate upheld upper-middle class British values. Even if he had not necessarily been to a public school, many of the qualities traditionally associated with the British public school were deemed essential; selection was based upon what Robert Heussler called “the traditional cult of the gentleman”.¹²⁸ These values included the characteristics of leadership, militarism, conservatism, sportsmanship or fairness, a strong sense of social propriety, manners and consciousness of British tradition.¹²⁹ In Furse’s opinion “public school training is of more importance than university training in producing the personality and character capable of handling the natives well”.¹³⁰ He made many attempts throughout his career to encourage candidates with this type of education.¹³¹

¹²⁵ Furse, *Aucuparius*, p.223, p.230

¹²⁶ M Perham, ‘Introduction’, in Heussler, *Yesterday’s Rulers*, p.xxiv

¹²⁷ R Hillary, *The Last Enemy*, 1950, p.15

¹²⁸ Heussler, *Yesterday’s Rulers*, p.41

¹²⁹ R Wilkinson, *The Prefects: British Leadership and the Public School Tradition*, Oxford, 1964; JA Mangan (ed.) *‘Benefits Bestowed’? Education and British Imperialism*, Manchester, 1988; A Penn, *Targeting Schools: Drill, Militarism and Imperialism*, 1999

¹³⁰ PRO/CO/877/1/37811 Furse, ‘Proposal for Holding the Tropical African Services Course at Oxford and Cambridge’, 01/04/1920

¹³¹ PRO/CO/877/4/11 Memorandum: ‘Scholarships from Public Schools to Oxford and Cambridge’, 30/05/1927; PRO/CO/877/4/16 ‘Public School’s Employment Bureau’, 1927–9. For a discussion of the connection between education and imperialism see Mangan (ed.) *‘Benefits Bestowed’?*

With the formal abolition of patronage as a means of entry to the Colonial Service it would be natural to assume a reduction in emphasis on status and social qualifications. In some ways this did occur: non-Oxbridge universities, although still not largely represented, gradually became more visible; the middle-classes too, after entering universities that were progressively more accessible to them, were increasingly seeing Colonial Service as a viable career. It was still a job for the educated elite, but less founded on social connections than in the pre-war period. The associations did not disappear entirely. Furse was in charge of recruitment until his retirement in 1948 and until then his conservative ideas held considerable sway. As one colonial historian assessed the situation in 1945, “the two way stations on the road to C [olonial] S [ervice] careers....were [still] the great British Public Schools and the two ancient universities of Oxford and Cambridge”.¹³²

These characteristics were seen as markers of breeding and gentility and were closely associated with broader upper-middle class prejudices over race, religion, gender and sartorial presentation. A strong, barely hidden, element of racism characterised Colonial Service recruitment. Advice on appointing an Indian doctor is illustrative: “[i]n dealing with Indian applicants our method so far had been to do all we can to avoid telling them openly that they are ineligible on racial grounds.” Rather brutally the CO allowed Indians to fill in all the application forms and then found “some excuse or other” to turn them down.¹³³ The nationalist agenda extended beyond even racial concerns to the point where candidates from the Dominions were regarded as a second best option. If a decision had to be made quickly, the British candidate was to be chosen over any foreign one every time.¹³⁴ White British men were considered by far the best choice, but it was known that this policy had to be conducted guardedly: “whatever happens, it is most important that no indication should leak out that men are rejected for Colonial Services on account of colour”. The same minute went on to say:

¹³² Heussler, *Yesterday's Rulers*, p.81

¹³³ PRO/CO/877/1/43122 Minute: Furse, Method of Dealing with Applications for Colonial Employment on the Part of Natives of India', 29/08/1921

¹³⁴ In times of economic difficulty in Britain the detrimental political and economic climate meant that British candidates had “strong claims to sympathetic considerations” over Canadian candidates. PRO/CO/877/2/6370 Furse to Falconer, 'Selection of Canadians', 24/04/1922

The gist of the matter is that for various reasons, into which I need not go, it has been found unwise to appoint to positions in the public services of almost all the colonies, persons who from a knowledge of their antecedents, or from their personal appearance, might be suspected of having a mixture of non-European (I mean of course, coloured) blood.¹³⁵

Similarly there was institutional discrimination on religious grounds.

Although theoretically non-Christian beliefs were no bar to a colonial appointment, they did often play a part in character assessments, particularly earlier in the period.

¹³⁶ Early comments in the patronage desk diaries reveal a “regular and virulent display of anti-Semitism”.¹³⁷

The requirement for physical fitness meant candidates would “stand or fall by the medical examination”.¹³⁸ This assessment, was also required for entry into physically demanding jobs, such as the army, but the emphasis on athleticism is surprising for a sedentary profession such as medicine which did not typically require sporting prowess.¹³⁹ Being a colonial doctor, however, laid stress on this quality and nowhere more so than in the taxing climate of tropical Africa. The Medical Adviser could deny entry to those who were “insufficiently developed physically”, just as the Private Secretary could apply the same type of check on those who were not “sufficiently developed from the point of view of character”.¹⁴⁰ This integral emphasis on sport and physical robustness was intimately connected (largely through the influence of public schools) with ideals of Empire.¹⁴¹ “Without hard exercise men

¹³⁵ PRO/CO/877/4/15 Minute: Furse, ‘Canadian University Graduates of not Pure European Descent’, 19/04/1927

¹³⁶ PRO/CO/877/3/950 Furse to Mr Fennell [University of Toronto], ‘Employment of Officers in the Colonial Service of Jewish Origin’, 24/01/1924

¹³⁷ Kirk-Greene, ‘Not Quite a Gentleman’

¹³⁸ PRO/CO/877/2/56081 Furse to Mr Trustlove [Oxford University Appointments Committee], ‘Eyesight Standard of Candidates for Appointment to the Colonial Service’, 30/11/1923

¹³⁹ Although it is noted that medical schools often emphasised sport too, especially in entrance interviews once they began with regularity.

¹⁴⁰ PRO/CO/877/3/57672 Minute: Furse, ‘Question of the Minimum Age Limits for Candidates for Appointment to Tropical Africa’, 6/12/1924

¹⁴¹ JA Mangan, *The Games Ethic and Imperialism: Aspects of the Diffusion of an Ideal*, 1998 [1986]; JA Mangan (ed.), *The Cultural Bond: Sport, Empire, Society*, 1992

in hot countries rapidly lose their health and often mental serenity. The result is a loss of efficiency and, in some cases, a tragic disaster".¹⁴²

Closely associated with physical fitness were ideas of mental strength and stability. The form candidates had to complete and give to the consulting physician asked for a declaration of whether they had suffered from any nervous complaint as well as asking if there was a history of insanity in their family.¹⁴³ This question not only suggested that mental disease was hereditary, but also assumed that the stresses of residence in a tropical climate might bring out undesirable psychological traits.¹⁴⁴ There were longstanding associations between residence in the tropics and the deleterious mental and physical effects of the hot sun and climate.¹⁴⁵ This belief, stemming from the earliest days of tropical exploration persisted until the end of the period, although by the 1930s it was often expressed publicly in more diluted and culturally acceptable idioms.¹⁴⁶ One danger claimed for tropical life was nervous exhaustion (sometimes termed tropical neurasthenia). It was chiefly on the basis of this enduring belief that those of weaker constitutions — namely women and children — were discouraged from spending extended periods of time in the tropics.¹⁴⁷ Since most Colonial Medical Service doctors served in Africa, they were

¹⁴² PRO/CO/877/4/16 *Public School's Employment Bureau Bulletin No.3A*, July 1929, p.20

¹⁴³ PRO/CO/850/46/11 'Standard Prescribed Form for Medical Examination for the Colonial Service', 1934

¹⁴⁴ This was in accord with some medical recommendations. 'The best kind of man to go to the tropics is the good ordinary type of Britisher, with a clear head 'well screwed on', an even temper, not over intellectual; one who can take an interest in things around, not unduly introspective, not ever sighing for the flesh-pots of Piccadilly...The unsuitable man is he who is a victim of migraine, headaches, any hereditary mental taint, or epilepsy; who bears heat ill, or suffers from insomnia, or is neurotic in any way". R Havelock Charles, 'Discussion on Special Factors Influencing the Suitability of Europeans for Life in the Tropics', *BMJ*, ii, 1910, pp.869-74, p.870

¹⁴⁵ Eg, K Ordahl Kupperman, 'Fear of Hot Climates in the Anglo-American Experience', *WMQ*, 41, 1984, pp.213-40; D Kennedy, 'The Perils of the Midday Sun: Climatic Anxieties in the Colonial Tropics' in JM MacKenzie, (ed.), *Imperialism and the Natural World*, Manchester, 1990, pp.118-140; M Harrison, "'The Tender Frame of Man": Disease, Climate, and Racial Difference in India and the West Indies, 1760-1860', *BHM*, 70, 1996, pp.68-93; M Harrison, *Climates and Constitutions: Health, Race, Environment and British Imperialism in India 1600-1850*, New Delhi, 1999

¹⁴⁶ J Johnson, *The Influence of Tropical Climates, More Especially the Climate of India, on European Constitutions; the Principle Effects and Diseases Thereby Induced, their Prevention or Removal, and the Means of Preserving Health in Hot Climates, Rendered Obvious to Europeans of Every Capacity*, 1813; E de Breton, *The Up-Country Child*, Surrey, 1951

¹⁴⁷ E Shorter, *History of Psychiatry: from the Era of the Asylum to the Age of Prozac*, New York, 2000, p.129; For neurasthenia in general see M Gijswijt-Hofstra and R Porter (eds.), *Cultures of Neurasthenia: from George Beard to the First World War*, Amsterdam, 2001

considered particularly exposed to “stresses that do not operate to the same extent in a temperate climate” which meant that selection techniques had to take this into consideration: “[t]he fundamental qualification for such an official is *mens sana in corpore sano* [a sound mind in a sound body]”, read the promotional feature on the Colonial Service as a career in a late 1920s issue of the *Public Schools’ Employment Bureau Bulletin*.¹⁴⁸ Repeatedly, “the importance of avoiding nerves” was cited as an important factor in the selection of the right sort of candidate.¹⁴⁹ Even at the end of the period, a proposal from the Governor of Uganda, Philip Mitchell, suggested that the tour of duty for MOs there be reduced from thirty to fifteen months, because “the climate of Uganda...has a deteriorating affect on mental efficiency”.¹⁵⁰ The CO still held, as late as 1939, that the East African climate was “liable to produce nervous manifestations after lengthy residence”.¹⁵¹

James Mangan and James Walvin have examined in detail the emphasis on morality in relation to societal values during this period, especially the way this perceived asset permeated middle-class opinion.¹⁵² The Colonial Service, too, laid explicit stress upon conventional moral values and specifically asked that candidates be sought who displayed good fibre.¹⁵³ The P.7 form to be completed by referees asked whether the candidate was “a fit and proper person” to hold a “responsible appointment in the Colonial Service”, requesting information on any potential character deficits “in connection with matrimonial affairs, temperament etc.”.¹⁵⁴ This

¹⁴⁸ PRO/CO/877/4/16 *Public Schools’ Employment Bureau Bulletin No.3A*, 1929, p.19

¹⁴⁹ PRO/CO/877/4/19 Minute: Furse ‘Recruitment of Candidates from Younger Universities’, 15/12/1927; Also the rationale behind rejecting candidates with speech impediments on the grounds that “a disability of this kind arising from some nervous disorder is sometimes liable to become worse in the tropics”, PRO/CO/877/8/16 Circular Despatch: to All Colonies and Protectorates, 11/07/1932

¹⁵⁰ PRO/CO/850/133/1 Governor of Uganda to Secretary of State, 4/11/1938

¹⁵¹ *Miscellaneous No.488: The Colonial Service, General Conditions of Employment*, 1939, p.16

¹⁵² JA Mangan and J Walvin (eds.), *Manliness and Morality: Middle-class Masculinity in Britain and America, 1800–1940*, Manchester, 1987

¹⁵³ PRO/CO/877/4/11 ‘Scholarships from Public Schools to Oxford and Cambridge’; RHL/MSS.Brit.Emp.s.415, Furse Papers, ‘First Memorandum for the Warren Fisher Committee’, 27/04/1929

¹⁵⁴ PRO/CO/877/15/17 Referees’ Statement, (P.7)

assessment could also be made at interview: a scribbled note on a candidate expressed doubts over his 'moral character'.¹⁵⁵

Another strong ideal was the ability to rule, to be a self-reliant and confident leader. This not only embodied public school leadership values, but additionally a certain tact and ability to respect native cultures and not offend native inhabitants.¹⁵⁶ The ideal choice of candidate was one who could "command the confidence and respect of the native; for it would not be an exaggeration to say that we rule these great areas primarily through means of personal influence".¹⁵⁷

Furse was looking for candidates who would feel part of the Service and so likely to uphold the traditions of Empire. The most desirable candidate therefore held a single-minded commitment to his work, was ideally a bachelor (at least at the start of his career), and someone who "takes up the Colonial Service as his career from the start". The "unsatisfactory candidate" would have "made but an indifferent success of life elsewhere and comes to us *faute de mieux* at the age of 27 to 35".¹⁵⁸ Indeed, one of the conclusions of the special departmental committee appointed to look into the Colonial Medical Service in 1920, which led to the unification of the EAMS, was that the unification was desirable particularly when one appreciated the "great esprit de corps" of the WAMS.¹⁵⁹ It was believed that dedication to service needed to be inculcated while young, the aim being to produce leaders loyal to the ruling government and proud to participate in all the pomp and ceremony that displayed and reinforced the values of Empire.¹⁶⁰ This dedication could partly be fostered through giving preferential treatment to sons of officers who had already served Empire in some capacity.¹⁶¹ Even after the loss of India in 1947, it was still

¹⁵⁵ RHL/MSS.Brit.Emp.r.21 Patronage Diary 1905, 24/05/1905

¹⁵⁶ An anecdotal example of this in Kenya (regarding the respect officers should pay to local religious customs) can be found in KNA/MOH/1/1758 Circular: to the Secretariat, 26/01/1910; see also PRO/CO/877/4/16 *Public School's Employment Bureau Bulletin No.3A*, 1929, p.20

¹⁵⁷ PRO/CO/877/6/11 Furse, 'Notes on the Scheme for Facilitating Recruitment for the Colonial Services from the Australian Universities', 04/09/1928

¹⁵⁸ PRO/CO/877/1/37811 Furse, 'Proposal for Holding the Tropical African Services Course at Oxford and Cambridge'

¹⁵⁹ [Cmd.939] *Report of the Departmental Committee*, 1920, p.6

¹⁶⁰ D Cannadine, *Ornamentalism: How the British Saw Their Empire*, Harmondsworth, 2001

¹⁶¹ See PRO/CO/877/4/11 'Scholarships from Public Schools to Oxford and Cambridge'

thought desirable that Colonial Service candidates embody some sense of the tradition of Empire; that “the ‘colonial Empire’ struck some chord in his mind even as a boy”. It was also felt that best candidates come from “stock that has proved its worth, generation by generation in the professions or in the public service”.¹⁶²

The good colonial servant believed in crown and country and therefore candidates of less certain political convictions were to be avoided. This went beyond considerations of race; it was an issue of national security. In 1925 Medical graduates from the Irish Free State, for example, were considered unsuitable for Colonial Service employment because their political loyalties could not be guaranteed. The opinion of J.E.W. Flood, a member of the Colonial Medical and Sanitary Advisory Committee, was very definite: despite possessing a reasonable medical school at Trinity College Dublin, “the service is better off without them [Irish Medical graduates]”, not least because they came from a disloyal country, rendering them “totally unsuited for any service under the crown”.¹⁶³ Concerns were similarly voiced that candidates from the Dominions lacked the prerequisite “tradition of service to the state” and were therefore unlikely to be as committed to the imperialist enterprise as their home-grown contemporaries.¹⁶⁴ Even when Dominion candidates were considered suitable, it was noted that particular care should be taken on “the question of personality”; presumably code for deficiency in allegiance.¹⁶⁵ Selection was therefore not solely associated with whiteness, but also with ideas of national loyalty. Even white settlers in Kenya complained that their peers from the home

¹⁶² Newbolt, *Appointments Handbook*, in Kirk-Greene, *On Crown Service*, p.194. Although it should be noted that in several important ways the *Appointment's Handbook* was an expression of ideas formulated before 1939.

¹⁶³ PRO/CO/877/3/51477 Minute: Mr Flood, ‘Applications for Colonial Appointments from Persons Resident in the Irish Free State’, 19/11/1925

¹⁶⁴ “[T]he idea of carrying on the government or the education of the dependencies of the Empire has not the same force in New Zealand as in England: there is not the background.”, PRO/CO/877/3/685 Minute: Mr Denniston [? illegible], ‘Applications from New Zealanders for Appointments in the Colonial Service’, 26/01/1926; See also Furse’s assessment of Canadian candidates received via the new procedures as “not up to the standard recruited at home” PRO/CO/877/6/11 Furse, ‘Note on Liaison with Universities in the Self-Governing Dominions (Report Requested by the Warren Fisher Committee)’, 06/06/1929

¹⁶⁵ RHL/MSS.Brit.Emp.s.415, Furse Papers, ‘Note to Colonel Amery on Work of the Appointments Branch,’ 19/02/1919

country were more likely to be offered a Colonial Service position than they themselves were.¹⁶⁶

Officers were united not only in their common aims and goals, but through a pride in their united government service. The obituarist of Alfred Mackie (Kenya and Tanzania), anonymous former colonial medical colleague, speaks instructively of “the fortitude and sense of service” which sustained Mackie’s work in Africa, despite his own deteriorating health.¹⁶⁷ But while the need to feel part of a broader group was an essential characteristic, this was combined with the requirement for the individual to be self-reliant and independent. The tropical world was different and challenging; racially and culturally isolating for the Europeans who went there. It therefore needed a special type of person to cope with life on his or her own. An early reference sets the tone for the rest of the period: The ideal colonial MO “must be a self-reliant man, and should early on in his career seek to exercise a clear and independent judgement. He must accustom himself to act alone, and to have the courage of his convictions, for he will seldom be able to summon prompt assistance from his brethren.”¹⁶⁸

These assessments of character were entirely bound up with the pervasive mind-set of the ruling classes. It was natural, for example, for Furse to uphold the values of the social group to which he belonged and to respect the same common denominators subscribed to by CO colleagues.¹⁶⁹ Similarly, the predominant focus on ideals of manliness reflected the inherent gender values of the period. The dearth of women working in the CO meant that women’s interests were rarely put forward and even when they were, the male dominated CO could summarily dismiss them as being irrelevant to the staffing composition of the Colonial Service.¹⁷⁰ Particularly up until the inter-war period, one of the main tasks of Colonial MOs was to provide

¹⁶⁶ *The East African Standard*, ‘A Colonial Office Visitor’, 15/01/1936, p.2

¹⁶⁷ ‘Alfred Mackie’, *BMJ*, ii, 1959, p.1262

¹⁶⁸ D Duckworth, ‘On the Education of Medical Practitioners for Colonial Service’, A Paper read at the First Inter-colonial Medical Congress, Amsterdam, 1883, pp.1-7, p.5

¹⁶⁹ R Hyam, ‘The Colonial Office Mind 1900-1914’, *JICH*, 8, 1979, pp.30-55

¹⁷⁰ Eg, it was decided that a women member should not be allowed to sit on the Colonial Services Appointments Board. PRO/CO/877/7/16 Mr Tomlinson, to Secretary, London and National Society for Women’s Service, ‘Colonial Service Appointments Board, Appointment of Members’, 20/01/1932

medical care for the European civil administration resident in the colonies, as these were mostly single men, women doctors were seen as being less relevant in the types of medical skills they could offer.

Many of these opinions on necessary character traits were reinforced by the views of the heads of the medical departments working in the colonies. When asked to assess the type of person he wanted in his Medical Department, William Kauntze (Director of Medical Services (DMS), Uganda) was unequivocal: “[g]et sturdy men; avoid temperaments. Highlanders and Irish give a lot of trouble”.¹⁷¹ In a later letter Kauntze was even more specific:

Professional qualifications are important, especially if they include additional ones in public health, but they are secondary to character so long as they indicate a reasonable standard of medical knowledge.

From my experience here and elsewhere temperamental people (particularly with the Celtic temperament) suffer more from climatic strain and are consequently much more difficult to manage departmentally. The really well-educated man with interests outside as well as medicine, usually serves us better than one with a narrower education.¹⁷²

Equally revealing are opinions voiced in the private correspondence of Mr Edward Cooke (who served on the interview committee for colonial medical appointments during World War One) to Ralph Furse. Character was so important that it could even surpass professional qualifications. The Colonial Medical Service did not need first-class doctors as much as needed ‘good types’, especially in times of recruitment shortfall:

For general appointments, I do not think that we need to attract the very best men. Such men are more useful at home. In the colonies we want a good all-round general practitioner with a good physique and a sporting temperament. Higher attainments are not required, and an unfit man for appointment in so far as there is probably no less satisfactory officer than a man who is too good for his job.¹⁷³

¹⁷¹ RHL/MSS.Brit.Emp.s.415, Furse Papers, Furse’s Diary [Typescript], 1935–6, 07/02/1936

¹⁷² RHL/MSS.Brit.Emp.s.415, Furse Papers, WH Kauntze to Furse, 06/03/1936

¹⁷³ RHL/MSS.Brit.Emp.s.415, Furse Papers, Memorandum: Furse to Milner. In contrast to this tone, from the mid 1920s onwards a concerted effort was made, at least synthetically, to raise the standards of all recruits to the Colonial Services in general, and the medical services specifically. Furse stated in 1927

Colonial Medical Service recruiters had a very clearly defined idea of the 'type' of person they wanted staffing the British imperial possessions. This type, broadly speaking, supported (even if it was not socially part of) a traditional and conservative worldview customarily associated with the British upper classes. It also upheld and reinforced the manly values of Empire by recruiting (principally) men who were white-skinned, loyal, sporting, firm-minded strong leaders. Academic attainments became progressively more important as the period progressed, but were not valued nearly as strongly. Character was the guiding principle of recruitment.

2.4 Recruitment Trends

The overall trends of colonial medical recruitment shed light on overarching issues that faced both recruiters and recruited throughout the period before World War Two. During the early years of Britain's tropical Empire, the CO presented a discouraging message about an individual's chances of gaining an appointment. The 1899 'Information as to Colonial Appointments', stated that unless the candidate was enrolled in one of the cadetship schemes or professionally qualified, there were "scarcely" any openings at all.¹⁷⁴ By 1908 this rather negative tone had softened: there were "few openings for candidates from this country except in tropical Africa".¹⁷⁵ The cautious phrasing was dropped altogether by the 1920s.

It is important to differentiate between number of applications made and the number of positions available: in the early period there were generally more applications than positions to fill. Analysis of a selection of Patronage desk diaries, although necessarily imperfect (interest in a medical career would not necessarily have been mentioned),¹⁷⁶ sheds some light on the popularity of the colonial medical career in relation to other services during the period before 1914. Although peaking

that the standards of medical recruits had improved enough to allow more "freedom of choice in the selection of candidates", meaning he no longer had to recruit those he actually felt were not of high standards. RHL/MSS.Brit.Emp.s.415, Furse Papers, Furse, 'Confidential No.38', p.11; The recruitment memorandum of 1935 confidently stated that "the standard of personal, educational, and professional qualifications has been raised and a field has been created for the exercise of special attainments not previously required in the Colonial Service". *Colonial Service Recruitment No.3*, p.6

¹⁷⁴ 'Information as to Colonial Appointments', *CO List*, 1899, p.347

¹⁷⁵ *Ibid.*, 1908, p.445

¹⁷⁶ Just as perhaps not all enquirers to the CO were mentioned.

in 1903 interest in medical positions was remarkably steady until just before the First World War started (Figure 2.1).

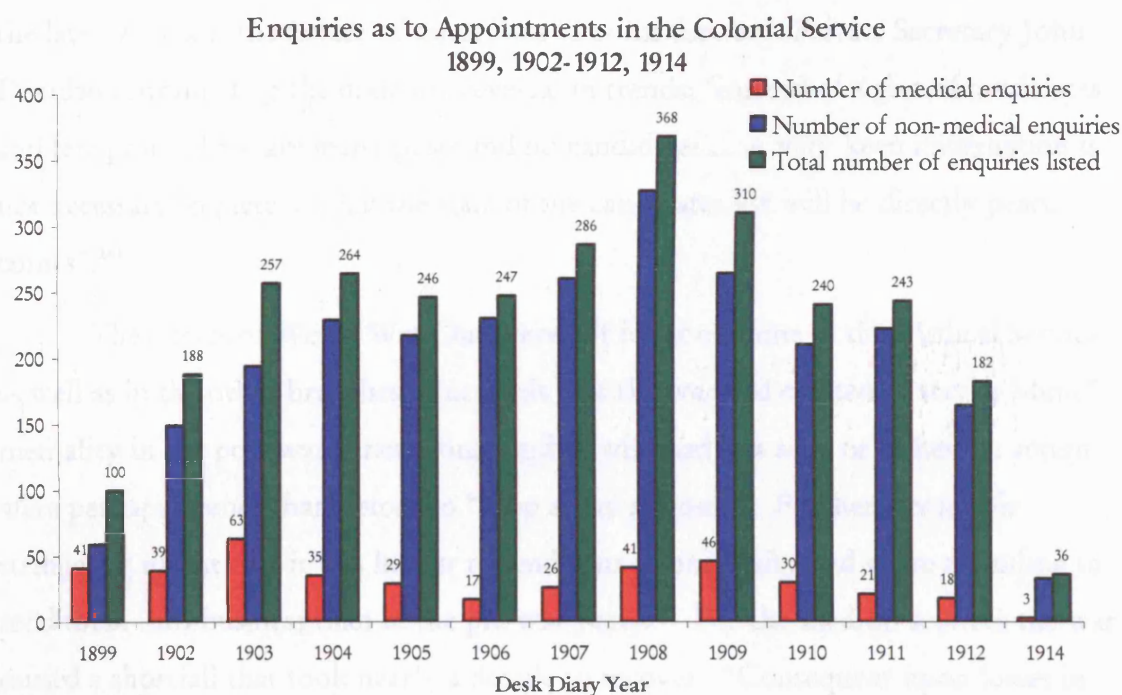


Figure 2.1: Appointment Enquiries for the Colonial Service, 1902-12, 1914¹⁷⁷

No official records were kept of actual recruitment numbers in the years preceding 1913, but the 1899 Selborne Report counted a total of 447 MOs in the Service of Empire for 1895.¹⁷⁸ In 1912 there were 23 Colonial Medical Service doctors in Kenya and 25 in Uganda, so new openings for doctors in this region were not plentiful, not least because in the first decade of the century West Africa was perceived as having the most pressing need for medical staff. Some impression of vacancies is possible. In 1899, for example, it was stated that an average of fifteen medical appointments a year was to be expected.¹⁷⁹ By the end of World War One the medical establishments of the African colonies were beginning to grow and it was

¹⁷⁷ Compiled from RHL/Mss.Brit.Emp.r.21 Patronage Diaries 1899, 1902-12, 1914

¹⁷⁸ Kirk-Greene, *On Crown Service*, p.16

¹⁷⁹ 'Information as to Colonial Appointments', *Dominions and CO List*, 1939, p.623

estimated that there would be “over 50” vacancies for doctors in the Medical Service overall.¹⁸⁰ Nonetheless, even when vacancies did increase, recruitment sometimes remained depressed. One of the problems plaguing the medical services right up to the late 1920s was the failure of candidates to come forward. Private Secretary John Davidson summed up the dramatic reversal in trends: “instead of a glut of candidates and few posts, there are many posts and no candidates.... A very keen imagination is not necessary to picture what the state of the candidates list will be directly peace comes”.¹⁸¹

The effects of World War One were felt for some time in the Medical Service as well as in the other branches. Furse felt that the war had created a “stay at home” mentality in the post-war generation; families who had lost sons or fathers in action were perhaps keener than before to “keep a boy at home”. Further, economic stringency meant that it was harder to send sons to university and more appealing to send them into business than in the pre-war years.¹⁸² For the medical services the war caused a shortfall that took nearly a decade to recover. “Consequent upon losses in killed and disabled, and the lack of new entrants to medical schools, there was a shortage in the supply of qualified doctors and, on account of the longer time required for qualification, the effect of this shortage was felt over a longer period of time”.¹⁸³ Coupled with the growing opportunities for doctors in the UK, “mainly owing to the expansion of various social services”, this meant that the starting salary offered looked yet more unappealing than formerly.¹⁸⁴ Furse admitted confidentially to the Secretary of State, Leo Amery, in 1919 that for some time the appointments branch had found itself in such a position where they had had to “take on several men since (and still have to) whom one would rather not see get a place”.¹⁸⁵

¹⁸⁰ RHL/MSS.Brit.Emp.s.415, Furse Papers, Memorandum: Furse to Milner

¹⁸¹ RHL/MSS.Brit.Emp.s.415, Furse Papers, JCC Davidson to Furse, 09/08/1916

¹⁸² RHL/MSS.Brit.Emp.s.415, Furse Papers, Furse, ‘Confidential No.38’, p.3

¹⁸³ *Ibid.*, p.11

¹⁸⁴ *Ibid.*

¹⁸⁵ RHL/MSS.Brit.Emp.s.415, Furse Papers, ‘Note to Colonel Amery on Work of the Appointments Branch,’ 19/02/1919

The trouble seemed to lie in the popularity of the Service as a career rather than in any deficiency in the number of doctors *per se*. In July 1920 a minute on the issue recorded:

The position as regards medical vacancies is that we have now about 100 vacancies in all, (mainly E Africa, W Africa and Malaya): we have had enquiries as a result of the last advertisement (in last weeks Lancet and BMJ) from about 25 medical men (British and apparently qualified) a few lady doctors...and a few non-British. I understand that, from previous experience, out of 25 enquiries, one cannot expect to obtain more than ten definite candidates, and this is scarcely sufficient to keep pace with the present wastage, apart from making up the arrears; and the position in E and W Africa, and Malaya can, I understand, justifiably be described as 'dangerous'.¹⁸⁶

By 1922 a low point had been reached resulting in retrenchments of existing staff, notably in Kenya.¹⁸⁷ Things had not improved by the mid-1920s and Furse later reflected how "At the end of 1925 there were about 130 vacancies unfilled; suitable candidates were not forthcoming and the position was definitely unsatisfactory".¹⁸⁸ One scheme proposed was to expand the recruitment base to the Dominions, initially in Canada, but later (it was hoped) in Australia, New Zealand and South Africa. Canada was thought "most likely to be of special use to us in supplying our very serious deficiency of doctors"; not only would it help the personnel shortage, but it was thought that the inclusion of Canadian doctors in the colonial medical staffs would advance relations with the self-governing Dominions in general. It was hoped that ties to England would be improved through Canadians "taking a definite share of the 'white man's burden'".¹⁸⁹

Unsurprisingly, this need to broaden the recruitment base for the colonial medical services did not extend to doctors of other races. Although some non-European doctors were employed on the Mauritanian medical staff and that of the West Indies, they were effectively ineligible for most Colonial Service appointments,

¹⁸⁶ PRO/CO/877/1/44273 Minute: 'Appointment of MOs to the Colonial Service', 21/07/1920

¹⁸⁷ KNA/MOH/1/10070 'Retrenchments in 1922'

¹⁸⁸ PRO/CO/877/8/18 Furse, 'Progress Report for the Appointments Department, No.2', 10/12/1931, p.8

¹⁸⁹ PRO/CO/877/1/6781 Memorandum: Furse to Mr Wood, 'Selection of Canadians', 11/08/1921

irrespective of their qualifications. With regard to East Africa, which contained a large Indian population, no formal declaration of this policy was inserted into the recruitment literature until 1925, but even in earlier times of severe recruitment shortage, it was considered preferable to have no MO rather than an Indian one.¹⁹⁰

If the immediate post-World War One years were ones of slump and slow recovery, the years between 1925 and 1929 were “marked by a large expansion of cadres and very high recruitment”.¹⁹¹ Despite protracted arguments over terms and conditions of service between the BMA and the Chief Medical Adviser to the CO, Thomas Stanton, this period saw the most concerted effort to enhance the Medical Service’s reputation through personal contacts with the Deans of London and provincial medical schools. The results were very positive; “a steady stream of well qualified and experienced candidates was regularly forthcoming”, and confidence was so high (albeit temporarily) that it was decided “it was no longer necessary to advertise the ordinary vacancies in the Medical Journals”.¹⁹²

Medical recruitment was going well in 1930,¹⁹³ but the situation deteriorated between 1931 and 1934, and although figures later improved, they did not return to the highs of the late 1920s. As can be seen from Appendix 7, however, the sharp reduction in medical recruitment that occurred between 1930 and 1931, was less dramatic than was experienced in other branches of the Colonial Service, including the Administrative Service. Indeed, the Medical attracted the most recruits in 1931 and was consistently, second only to the Administrative Service as the biggest overall recruiter up to 1939. Ralph Furse was quietly confident that, although recruitment to most branches of the Service were in a troubled state, the situation regarding

¹⁹⁰ “Indians have not yet shown the fitness to govern themselves, much less others”. PRO/CO/877/1/43122 ‘Applications by Natives of India’. This was interesting as there were Indian doctors in the IMS and Syrian or Sudanese doctors in the Sudan Medical Service.

¹⁹¹ PRO/CO/877/8/18 Furse, ‘Progress Report for the Appointments Department, No.3’, 18/03/1932, p.1

¹⁹² PRO/CO/877/16/16 ‘Colonial Medical Recruitment of Medical Officers’, 06/1938

¹⁹³ “The tide is very much with us at the moment in regard to medical recruitment and I am very anxious to take advantage of it and consolidate our position”, Furse minute: PRO/CO/877/7/8 ‘Visit by Major Hutchinson’; in contrast to this metropolitan view, the Governor of Uganda wrote to the Secretary of State in the same year (1930) that he considered the need for new medical recruits as a matter of “considerable urgency”. PRO/CO/822/23/2 Governor, Uganda to Secretary of State, 27/02/1930

medical recruitment was, contrastingly, “satisfactory”.¹⁹⁴ Other figures produced by Furse show that career interest in the Colonial Service was increasing. By 1931 the CO received more enquiries and interviewed more (and better) candidates than ever before. In Furse’s assessment the profile and popularity of the Colonial Service had substantially improved even if there were very few positions available for successful candidates to fill.¹⁹⁵

The anomaly of relatively sustained medical recruitment throughout the depression of the 1930s has not yet been analysed by historians. Furse put it down to the fact that doctors were drawn from “ready made material” meaning that in times of economic stringency they could serve successfully in the Colonies without having further public money spent upon them, unlike Veterinary, Administrative or Forestry officers, for whom a specialised training course before departure was imperative.¹⁹⁶

Most services in the 1930s lost staff through retrenchment (redundancies). It was estimated as early as 1932 that approximately one thousand retrenchments had taken place in a year and a half, though the medical services had, once again, not been hit particularly hard.¹⁹⁷ The figures for the EAMS bear this out: compared to other parts of Africa — particularly the Gold Coast — Kenya, Uganda and Tanzania did not suffer too severely.¹⁹⁸ Furse in typically loyal style even gave a positive spin to the problems faced during the early 1930s: “however tragic and regrettable” retrenchment had the advantage of having “relieved the Service of its weakest elements”.¹⁹⁹

¹⁹⁴ PRO/CO/877/8/18 Furse, ‘Progress Report for the Appointments Department, No.1’, p.2

¹⁹⁵ *Ibid.*, pp.3–4; p.9

¹⁹⁶ Furse seems to be implying that the DTM&H was not absolutely essential for medical candidates during these types of periods. PRO/CO/877/8/18 Furse, ‘Progress Report for the Appointments Department, No.2’, p.9

¹⁹⁷ “As regard Medical, half a dozen are Senior Medical Officers nearing normal retirement. The remainder were appointed in recent years, one or two of them have been replaced elsewhere, and the retrenchment of others is not likely to attract attention in medical circles” PRO/CO/877/9/6 Furse, Statement [on the Effects of Retrenchment] to HA Roberts [Cambridge University Appointments Board], 01/02/1932

¹⁹⁸ PRO/CO/850/9/1 ‘Retrenchment: General Summary and Statistics’, 1932

¹⁹⁹ PRO/CO/877/10/11 Furse, ‘Progress Report for the Appointments Department, No.3’, p.26

Towards the end of the 1930s, however, quiet optimism was replaced by mounting concern: medical applicants were simply not coming forward in anything like the numbers needed to sustain, let alone extend, the medical services in the Colonies. Unease was so great that in 1938 it was decided to set up a special committee to look into these problems. As the committee reported, since 1935, “the number of [medical] applicants has been limited, so much so that it is seldom that there is more than one applicant for a particular post”. Furthermore, “the general standard of these applicants cannot be regarded as high”.²⁰⁰ In order to understand and assess the phenomenon, the various heads of medical departments in the colonies were consulted and the opinions of the men in charge of recruitment to the military medical services and the IMS were canvassed to see if they were also experiencing such trends. The results were worrying: although the Navy and Air Force medical services had noticed a decline in applicants, the RAMC and the IMS reported that recruitment, though not up to capacity, had, nevertheless, “improved very much”.²⁰¹ The final report of this special committee located four problems at the root of the downward trend: first, the effects of the depression, which meant that many well qualified and suitable candidates had been turned away, resulting in the image of a Service difficult to get into (even for those with experience); second, that retrenchments had contributed to a sense of “uneasiness” over the stability of the career; third, that competition from similar services had increased;²⁰² fourth the perception that wives or fiancées were not encouraged in the tropics (especially West Africa) had allegedly put off many young doctors, a point that was of increased importance in the 1930s when “independent enquiries” confirmed to the CO that doctors were marrying younger than ever previously.²⁰³

²⁰⁰ PRO/CO/877/16/16 Report: ‘Recruitment of Medical Officers for the Colonial Medical Service’, [n.d. c.1938]

²⁰¹ PRO/CO/877/16/16 Minute: AJ O’Brien, Chief Medical Adviser to the CO, 07/06/1938

²⁰² “[T]he conditions of service for officers in the Fighting Services, the IMS and the Sudan have been much improved; the London County Council and Local Authorities have increased their establishments and improved terms of service; the newly qualified doctor is in greater demand and can earn £350 per annum with quarters, as an assistant in general practice.” PRO/CO/877/16/16 ‘Colonial Medical Recruitment of Medical Officers’

²⁰³ *Ibid.*

Among the suggestions put forward to improve the situation was the appointment of doctors immediately after qualification followed by experience in the hospitals of the colony to which they were posted (rather than sending them out to a district, as was normally done). It was hoped that this would enable the CO to select the best products of the medical schools, before they were lured away by the offer of a permanent hospital position. This idea was dismissed as being impracticable, not least because hospitals in the territories varied so considerably that they could not be guaranteed to train new staff properly. It was thought best to revive connections with the Deans of medical schools and to pursue a vigorous promotional campaign, revitalising the service's reputation and expunging any myths that may have resulted from the problems of the preceding years.²⁰⁴

Yet, scarcely had these plans been formulated, when the outbreak of the Second World War brought a further destabilising knock to recruitment. Hurriedly, the CO put together a series of letters and articles for publication in *The Times* in an attempt to "reassure any such candidate, who may be in doubt where his patriotic duty lies. He may feel absolutely confident that, in offering his services to the Colonial Office, he is acting in accordance with the national interest". It was stated that this admonishment applied with "special force" to the Colonial Medical Service:

In the tropical countries of which the Colonial Empire so largely consists, the problems of public health are of basic importance. We simply cannot afford to fall back; nay more, we cannot afford not to go forward. The Colonial Office therefore must continue to recruit young doctors for appointments in the Colonial Medical Service, and it is earnestly to be hoped that suitable candidates will continue to come forward.²⁰⁵

The Colonial Medical Service clearly experienced different recruitment tensions at different times. Although few vacancies arose before World War One, demand for colonial doctors was high from 1914 until the mid 1920s. Unfortunately, for various reasons, candidates did not come forward in anything like the numbers needed effectively to supply the growing medical needs of Empire after the war. An

²⁰⁴ It was also hoped to organise a series of promotional articles in *The Times*. *Ibid*.

²⁰⁵ PRO/CO/850/153/18 Draft letter: G Tomlinson to *The Times*, 'Colonial Medical Service, Wartime Recruitment', 01/1940

extensive recruitment drive in the late 1920s specifically aimed at medical schools, together with improved relations with the BMA and the receding effects of the War, ushered in a period of relative boom. Following this period of prosperity Colonial recruitment fell as the effect of the worldwide financial depression made itself felt, but the Medical Service did not suffer as badly as other Colonial Services. By 1935, just when other branches were beginning to make a recovery, medical applications again became worryingly low — a state of affairs that continued until after World War Two.

2.5 Terms and Conditions of Colonial Medical Employment

Once a place became available on the Secretary of State's list of colonial vacancies an offer of employment was sent out to the successful applicant. This letter normally revealed the place where the officer would be posted and informed him when and where he should attend the course of instruction in tropical medicine and hygiene.²⁰⁶ All officers, once employed by the CO, were subject to three tiers of rules and regulations: first the general *Regulations of His Majesty's Colonial Service*, which was updated yearly and covered all the various services in all the colonial territories; second the "Laws, Regulations and General Orders" of the dependency in which they were to serve; and third any special terms or conditions particular to each individual's appointment.²⁰⁷ Together with the appointment letter, each selected candidate was also given a pamphlet outlining the particular terms on which they would be employed in the region to which they had been posted.²⁰⁸

MOs for East Africa were initially employed for a two-year probationary period (three years in West Africa). Subject to satisfactory performance (which for most of the period included passing local Kiswahili examinations as well attaining the

²⁰⁶ Ultimately officers would have received two letters of appointment, one from the CO and another from the colonial government in which they were to serve. KNA/MOH/3/247 Letter of Appointment: Under Secretary of State to P Ross', 14/09/1925; RHL/MSS.Afr.s.1421, Papers of P Rawson, 'Letter of Appointment: Acting Chief Secretary, Uganda to Rawson', 08/02/1922

²⁰⁷ *Miscellaneous No.441: The Colonial Medical Service, Special Regulations by the Secretary of State for the Colonies*, 1934, p.3

²⁰⁸ In the case of East Africa, *African No.973*

Diploma or Certificate in Tropical Medicine and Hygiene²⁰⁹), appointments were made permanent.²¹⁰ In the East African countries probationary service, once effectively passed, was counted as pensionable.²¹¹

Pay was a constant bone of contention. It had been a central issue in the BMA's arguments with the CO over terms and conditions for medical staff in the 1920s.²¹² When the first MOs were appointed in Kenya and Uganda the starting salary was £400, with the PMO drawing a salary of £650.²¹³ By 1939 the starting salary for MOs in East Africa had risen to £600 per annum, an unchanging figure since the beginning of the 1920s.²¹⁴ Even after unification and the accompanying standardisations, East African MOs received the lowest starting salary, £60 less than the yearly rate offered to new medical recruits to the West African territories, and £100 less than those starting work in Malaya.²¹⁵ Although yearly salaries and allowances were given in pounds sterling, up until March 1922, salaries in East Africa were paid in local florins, at a fixed exchange rate of 10 florins to the pound.²¹⁶ This was eventually changed in all three territories to payment in East African shillings, issued at a fixed rate of twenty shillings to the pound.²¹⁷

The financial depression of the 1930s did not help matters. Many of the colonies were so short of funds that they imposed temporary levies on salaries in the early 1930s, leave moratoria, suspension of local allowances and compulsory retirement.²¹⁸ In response to these financial difficulties, and to the negative publicity colonial salaries received in the medical press, later editions of CO memoranda

²⁰⁹ *African (East) No.1103: Regulations for the East African Medical Service*, 1925, p.4; *Colonial Service Recruitment No.3*, p.15

²¹⁰ *Miscellaneous No.99*, 1921, p.5

²¹¹ *Colonial Service Recruitment No.3*, p.14

²¹² BMA/E/1/41/1 Conditions of officers within the Colonial Medical Service, from 05/11/1919 to 27/04/1926' [My description]

²¹³ PRO/CO/543/1 EAP Bl.Bk., 1901-2; PRO/CO/613/1 UP Bl.Bk., 1901-2

²¹⁴ *Miscellaneous No.99*, 1921, p.5

²¹⁵ Although there was a note that these were under the process of review. 'Information as to Colonial Appointments', *Dominions and CO List*, 1939, p.627

²¹⁶ *Miscellaneous No.99*, 1921, p.5

²¹⁷ *Miscellaneous No.99*, 1923, p.5

²¹⁸ PRO/CO/533/397/6 Compulsory Retirements, 1930; PRO/CO/533/415 Moratorium on Leave, 1932; See also BMA/E/1/41/3 *Corrigenda to the Colonial Service Recruitment Series of Memoranda*, 1932

concerning the terms of employment of Colonial MOs stressed the advantages of the *overall* remuneration package. Although the salary rate might not have seemed particularly competitive on first impression “the actual value of an appointment is considerably greater than is indicated by the salary alone”.²¹⁹ Current and prospective employees were reminded to take into consideration the pensionable nature of the position; whether income tax was payable; accommodation and other local allowances; and the provision of free sea passages.²²⁰

Salaries usually rose yearly in fixed increments with certain ‘efficiency bars’ set within each scale. These ‘efficiency bars’ were fixed points within the capped salary scale beyond which an officer could not progress unless he had fulfilled certain requirements. In the very early years passing an efficiency bar could mean simply satisfying the DMS’s requirements for satisfactory service. It was later stipulated that this should normally involve improvement of their professional knowledge through taking a special course of study. In 1921, for example, a new MO’s pay started at £600, and rose in annual increments of £25 to the top end of the salary scale for that level of appointment, which was £900. This meant that it could take a doctor, provided they passed their efficiency bars (set at £700 and £800), 12 years to reach the top end of their pay-scale.²²¹ Promotion gained through reaching the top end of the pay scale was rightly portrayed as being very slow.

Although starting-rate pay for MOs was the same in 1934 as it had been in 1920, after the unification of the medical services in 1934, and accordance with the goal of standardisation, a single efficiency bar was set within that pay-scale at £840. Types of study acceptable for passing this bar were specified as a further degree, a specialist medical or surgical qualification, or “a recognized diploma or degree in public health, sanitary science, or State medicine”. These requirements reflected the growing emphasis within the Colonial Medical Service, from the 1930s onwards, towards specialised personnel.²²²

²¹⁹ *Colonial Service Recruitment No.3*, p.13

²²⁰ *Ibid.*

²²¹ *Miscellaneous No.99*, 1921, p.5

²²² *Colonial Service Recruitment No.3*, p.16

A few positions were available at a slightly higher starting rate. New recruits possessing the Diploma in Public Health (DPH) were usually recruited as Medical Officers of Health (MOH) and received £50 to £100 per annum above the standard MO's salary, (though the supplement was non-pensionable).²²³ Some positions had a "duty allowance"; an extra, non-pensionable, emolument paid to officers who took on extra duties, usually but not always, on a temporary basis.²²⁴ Another similar allowance was for sleeping sickness duty:

Some called it a 'risk allowance', and others regarded it as compensation for the hardships of bush life and frequent foot safaris. There was one man who refused it; he was the late Dr J[ames]F[rederick] Corson, who maintained that his salary was adequate reward for any risks he undertook.²²⁵

During the early years officers were given an 'outfit' allowance in advance of their first trip, to help them to purchase clothes and equipment necessary for the tropical climate. This was abolished in the early 1920s,²²⁶ but newly appointed officers were frequently offered an advance of a month's pay to cover any initial settlement expenses.²²⁷ A final (temporary) allowance was the war bonus, which was introduced for officers serving in Africa during the First World War in order to compensate them financially for the extra professional burdens imposed by the war.

With these financial allowances and supplements, doctors in East Africa did perhaps not fare particularly badly. All three countries in this study were among those where no income tax was payable by European residents,²²⁸ and MOs were

²²³ *Miscellaneous No.99*, 1921, p.6; *African (East) No.1103*, p.4; Also KNA/MOH/3/246 N MacLennan, Appointment Letter, 27/11/1926. Later editions of Colonial memoranda for East Africa do not mention the salary supplement for MOHs, so it was most likely stopped in the 1930s. Any supplement that was granted was, furthermore, tied to the position of MOH, as opposed to the possession of the DPH *per se*. PRO/CO/850/120/6 AJ O'Brien, Chief Medical Adviser to the CO to C Hill, [Deputy Secretary, BMA], 23/05/1938

²²⁴ *Colonial Service Recruitment No.3*, p.17

²²⁵ HG Calwell, 'Nineteen Years in the Colonial Medical Service', *UMJ*, 65 (supplement), 1993, pp.(s)1–(s)42, p.(s)5

²²⁶ Outfit allowances were continued for MOs appointed to West Africa for a longer than they were in East Africa, presumably because conditions were regarded as considerably worse in the West. *African (West) No.678: Information for the Use of Candidates for Appointments on the West African Medical Staff*, 1930, p.14

²²⁷ Jeffries, *Colonial Empire*, p.120; *African No.973*, p.4

²²⁸ *Colonial Service Recruitment No.3*, p.19

allowed quarters free of rent for themselves and their families.²²⁹ They were also given free first-class passage to the country in which they were to serve on first appointment and subsequently whenever they went on leave. At first there was some debate as to whether the fares of accompanying wives and children should be paid for. By the 1920s it had been decided that newly appointed officers would receive half the cost of these extra passages,²³⁰ and by the 1930s wives and children were paid for at the full rate, so long as they followed the Officer within twelve months of his appointment.²³¹ In 1935 the CO thought better of its generosity, stating only that a married officer posted to East Africa “*may be granted an allowance towards the cost of his family’s passages*”.²³²

Each tour of duty was followed by leave, offered on full salary. For the East African territories the recommended tour of service was officially between twenty and thirty months long.²³³ The officer was then entitled to five days leave for every month served, so that an officer having finished a thirty month tour of duty could expect to receive 150 days (approximately 5 months) leave.²³⁴ These terms were tightened up around 1925. While the length of the tour of service remained the same, leave entitlement on full pay was reduced to 2½ or 3½ days per month’s residential service depending on the district in which the officer served.²³⁵ Sick leave was available, up to a maximum of six months full pay, with the option of a six months extension on half-pay in for officers who would “ultimately be fit to return to East Africa”.²³⁶

²²⁹ Unlike in West Africa

²³⁰ *African (East) No.1105*, p.4

²³¹ *Colonial Service Recruitment No.3A*, p.20

²³² [My italics] *Colonial Service Recruitment No.3*, p.20

²³³ Although the relatively salubrious climate of Kenya meant that the maximum tour was raised to thirty-six months. *Ibid.*

²³⁴ The period taken travelling to and from leave was not subtracted from this entitlement. *Miscellaneous No.99*, 1921, p.11

²³⁵ Under these new leave conditions officers could also receive fourteen days local leave and, subject to official approval, extensions of leave in cases where they were sick or needed the extra time to attend courses of instruction. *African (East) No.1105*, p.4

²³⁶ *Colonial Service Recruitment No.3*, p.20

Before the Warren Fisher Committee, pensions were granted to officers who had served in the Colonial Service for twenty years or had reached the age of 50: whichever was sooner.²³⁷ In the years before the recession of the 1930s, however, an officer could apply to continue his service past the official retirement age, subject of course to Government consent.²³⁸ After 1934 a general arrangement was reached whereby pensions were calculated at the rate of 1/600th of the officer's salary and some allowances (such as the value of free living quarters) received for each month of service, irrespective of any transfers that may have occurred between territories. All officers were entitled to this pension after having completed ten years continuous service.²³⁹ Any officer who wanted to retire earlier could do so on a gratuity, which was essentially a one-off payment taken in lieu of other pension rights. If an officer decided to take this option in East Africa he was entitled to a lump sum of £1000 after nine years' service (of which a minimum of six years had to have been spent in residence) or £1,250 after twelve years (of which a minimum of eight had to have been spent in residence).²⁴⁰ If an officer died in Service, his family received a sum equal to the gratuity to which he would have been entitled, depending on his length of service.²⁴¹ Officers also were obliged (even if unmarried) to contribute from their salaries to an insurance policy for widows and orphans in event of an officer's death. The details of this were famously complicated and were extensively overhauled and reviewed in 1936.²⁴²

The nature of the job necessarily required quite a large amount of travel. This was paid for as standard by the colonial government. By the 1930s, officers were encouraged to acquire their own cars or motorcycles to take them through their

²³⁷ After 1934 the upper age limit was raised to fifty-five and the twenty-year service requirement was abolished. *Ibid.*, p.21

²³⁸ *Miscellaneous No.99*, 1921, p.12

²³⁹ A supplementary pension scheme was also provided in the case of forced early retirement. Jeffries, *Colonial Empire*, pp.112-3, p.114

²⁴⁰ *Miscellaneous No.99*, 1921, p.5

²⁴¹ *African (East) No.1103*, p.4

²⁴² The Watson Committee, 1936

districts; although Government would not pay for the vehicles, petrol costs were reclaimable.²⁴³

The most controversial and hotly debated regulation centred on whether medical practitioners should be officially allowed to undertake private practice whilst also holding a government position.²⁴⁴ The general CO Regulations throughout this period expressly stated that Colonial Officers' pay was "fixed on the assumption that his whole time is at the disposal of the Government [and therefore he] is prohibited from engaging in trade, or employing himself in any commercial or agricultural undertaking" or to "undertake any private agency in any matter connected with the exercise of his public duties".²⁴⁵ In fact private practice was never explicitly banned in any of the regulations issued by the CO specifically dealing with doctors. The CO realised the potential backlash if an avenue allowing officers to more money and increase their social standing was closed. Throughout the period debates occurred at home and abroad over what was enviously considered by many non-medical colonial servants to be a substantial perk. Disquiet over the issue focused upon three main areas. First, the conduct of private practice presented an invariable clash of interests, not least in terms of time spent attending to government matters. Secondly, there was a worry that doctors would charge for services (perhaps even using Government medicines) which under the colonial government's system could also be obtained free of charge and effectively creating a two-tier level of service. Last, concerns were voiced that doctors were simply making too much money in this way, and in so doing distorting the aims and objectives of the Colonial Medical Service career, which Government did not want associated with lucrative private practice. During the interwar years it became obvious that it would be impossible to prohibit private practice entirely. All the high administrative posts as well as laboratory and sanitary appointments, were expressly prohibited from practising, but the rank and file MOs were allowed to undertake practice so long as it did not "interfere with the faithful and efficient performance of their official duties" and on the express understanding

²⁴³ *Colonial Service Recruitment No.3*, p.18, p.29

²⁴⁴ This was a big issue and is addressed further in Chapter 4

²⁴⁵ *Regulations for His Majesty's Colonial Service*, 1908, pp.12–13; 'Colonial Regulations', *Dominions and CO List*, 1939, p.866

that any abuse of the system would result in the privilege (and it *was* constantly stressed as a privilege) being withdrawn from the individual concerned.²⁴⁶

Supplementary fees could also be earned through undertaking other duties, such as conducting *post-mortem* examinations, acting as expert witness in local court cases or processing passport applications. To standardise the payments doctors could extract, fees charged for undertaking these extra duties were fixed throughout the Colonial Medical Service.²⁴⁷ Medical care for all government officers was free, as it was for the families of all officers in the lower ranks of the Colonial Medical Service.²⁴⁸

The Colonial Medical Service system of promotion was based on meritorious service and senior appointments were usually made from within the Service. Promotions were put forward to the Secretary of State for approval by the head of each Medical Department through the local Governor. The assessment of an Officer's suitability would usually be conducted through annual confidential reports that the DMS submitted for every member of staff working in his territory.²⁴⁹ Although the official ethos changed very little throughout the period, it became specifically stressed after 1930 (probably in response to arguments put forward by the BMA that promotions could take years to attain) that all officers could theoretically be considered for promotion if they had "rendered good service" regardless of whether they had reached the top of their salary scale. After the unification, transfers became used even more frequently as a way to forward promotions. If no senior position was available in their current location, officers deserving of advancement were offered a higher position in another territory. Such transfers were consequently rare during the early years of an officer's career.²⁵⁰ Jeffries outlined the situation in 1938. A Colonial MO "may expect an initial salary of £600, more or less. Provided

²⁴⁶ *African (East)* No.1103, pp.7–8, quotation, p.8

²⁴⁷ *Ibid.*, p.8. In Kenya, these fees were suspended (to great discontent) during the recession and had still not been restored by 1936. RHL/MSS.Brit.Emp.s.415, Furse Papers, AP Paterson, DMS, Kenya, to Furse, 19/02/1936

²⁴⁸ *African (East)* No.1103, p.6

²⁴⁹ Eg, KNA/MOH/1/685, Annual Confidential Reports, [n.d. c.1908–10]

²⁵⁰ *Colonial Service Recruitment* No.3A, p.5

that he is reasonably efficient in the performance of his duties, he may normally count on reaching, within from 13–15 years, a salary of £1,000, plus allowances and, in many cases, some private practice...even the average officer may legitimately aspire to reach at least the Senior Medical Officer grade, and there are reasonable chances of rising higher still.”²⁵¹

Essentially, the terms and conditions for MOs changed very little throughout the period. After the Warren Fisher Committee, certain precise criteria were introduced and other terms were expressed less ambiguously, but there was very little material improvement in salary or leave entitlement. The unchanging nature of pay, leave, allowances and pension rights led to much disgruntlement among the medical personnel.²⁵² These regulations, provided the framework under which officers were employed and largely prescribed and delineated their actions. What this actually meant for Colonial MOs in terms of daily practice and duties is discussed in Chapter 4.

* * *

Joining the Colonial Medical Service involved a set of procedures pre-arranged by the British Government. It naturally presented a much more bureaucratic process for medical graduates than they might expect to go through when opting for other medical careers. Appointments were not based solely on academic and professional qualifications, but on a mixture of objective and subjective criteria aimed at selecting the type of person who could operate best under the perceived stresses of the tropical world. This careful selection procedure, with its emphasis on personality, suggests that doctors working in the colonies had a broader socio-political rôle to play than they necessarily would at home. They needed to have the sorts of characteristics that could survive well in the potentially isolated and alien environment; more importantly, they were symbols of the ruling country and had to be assessed in terms

²⁵¹ Jeffries, *Colonial Empire*, p.153

²⁵² David Potter has explored the relationship between recruitment and terms and conditions of employment in the Indian context, he has, furthermore, argued for the personnel factor in the breakdown of colonialism in India. DC Potter, ‘Manpower Shortage and the End of Colonialism. The Case of the Indian Civil Service’, *Mod.AS*, 7, 1973, pp.47–73

of their potential to uphold its values. For these reasons Furse insisted on interview as the central tool of recruitment, and selection right up to the 1950s was based upon many of the same central principles. That is the picture from the side of Colonial officialdom, but what of the appointees themselves? Why, when terms and conditions of service were considered to be relatively inflexible and uncompetitive, did doctors choose the career over other professional alternatives available to them? That is the subject of the next chapter.

3. Reasons for Being a Doctor in East Africa

One wonders why so many medical men chose tropical Africa when they could have lived an easier life in a temperate climate and under less burdensome conditions.¹

[T]he Service offers an attractive career for the keen and well-qualified young officer. It is attractive professionally, financially and socially.²

The reasons why doctors chose to undertake public service careers in Africa were necessarily diverse. Yet, however multifarious individual motivations were in their different personal (and public) influences, certain common themes can be identified as informing the decisions of colonial doctors before World War Two. Some were economic (the attractions of regular pay and a future pension); some practical (it was, for the 'right sort', easy to get the job); some were social (the respectability and prestige associated with the career); some were professional (the chance to gain practical tropical medical experience); and all were culturally determined (the then fashionable allure of Empire). Although doctors in their reminiscences sometimes identified a single, dominant reason for their career choice, on closer scrutiny, they all contribute to a much broader world picture. In some ways the point is commonplace: doctors were influenced in their choices by the circumstances of the period in which they lived. It is still worthwhile, however, to explore the individual and group motivations that occurred on much more than just the level of conscious choice.³

The divisions between the main factors that influenced Colonial Service career choices discussed in the following pages have been created for thematic order. They are inevitably false distinctions, as varying combinations of inter-related factors contributed to individual choices.⁴ What is more, the weight of each factor changed

¹ A Beck, *A History of the British Medical Administration of East Africa: 1900–1950*, Cambridge, MA, 1999 [1970], p.206

² AGH Smart, 'An Impression of Life in the Colonial Medical Service', *St. THG*, 37, 1939, pp.123–6, p.126

³ This is a subtle acknowledgment of a complex series of interrelated factors, rather than taking a Marxist stance such as that expounded by Robert Young, which argues for a coercive force from a common context imprinted upon the ideas and actions of historical figures. RM Young, *Darwin's Metaphor: Nature's Place in Victorian Culture*. Cambridge, 1985

⁴ Indeed, most doctors list two or three reasons when describing why they entered the Service.

relative to other social economic and cultural influences of the time while the balance between factors was never static. In the earlier period, for example, the missionary connection, riding on the back of Livingstone's popularity, may have encouraged ideas of working in Africa, in the later period this was less persuasive and was replaced by growing professional individualism among doctors specifically and more general ideas of Empire building. The post-war generation of doctors had very different priorities from their pre-war equivalents and by the 1920s a new rhetoric of development began to replace former ideas of Empire building for exclusively European purposes. Although the period is chronologically short, it covers a time of great social flux.⁵

This chapter explores the various stimuli affecting colonial medical career choices, interweaving personal recollections of MOs with broader historical social and economic factors. As much of the evidence is autobiographical, compiled from personal papers, biographical descriptions in obituaries and other sources, it cannot be said to represent the unanimous opinion of all Colonial MOs.⁶ Naturally, only a small (and generally elite) proportion of the 424 doctors identified left detailed accounts of their lives or had obituaries written about them. Moreover, the accounts were written from varying perspectives and with different motives, so that they are inevitably eclectic and non-standard.⁷ The evidence therefore lacks the uniformity and executive systematisation provided by official papers. Nevertheless it yields a previously unexamined personal element in Colonial Medical Service history. Recurrent themes and shared standpoints can be easily identified and related back to arguments over subjective recruitment criteria presented in the previous chapter. Since individuals were specifically chosen by the CO for the way it was hoped they would contribute to the shared perspectives and common values of the group, this

⁵ One disappointment is that the vast majority of reminiscences and obituaries occur for doctors who joined the EAMS after 1920 and very little personal evidence has been left for participants in the early, formative, era. This is partly because there were few colonial medical staff during that time, and perhaps also because it was only later that the group came to recognise its comparative historical significance.

⁶ For example, *Munk's Roll or Lives of the Fellows of the Royal College of Physicians of London*, (various editions); *Who was Who* (various editions); R Drew, *Commissioned Officers in the Medical Services of the British Army, 1660–1960*, 1968

⁷ 21 Colonial MOs who served in East Africa sometime between 1893–1939 have deposited papers at Rhodes House, Oxford; however, only 10 of these make any specific reference to why they joined the Service. Obituaries or biographical entries were found for 107 MOs.

understandably revealed some unity of purpose. Such issues, and others discussed below, help piece together an informative perspective of how and why doctors perceived the career as they did.

3.1 The Economic Factor

Any decision over job choice necessarily has to take account of its economic viability. Although recruitment to the colonial medical career fluctuated during the period before the Second World War, the highs and lows were related more to pressures on the medical profession at home than to any particularly persuasive financial appeal of the career itself. The colonial option did have certain features that made it desirable in many doctors' minds, but these were rarely cited as being purely (or even partly) economic. When it was difficult for doctors in the United Kingdom to find secure jobs a position in the Colonial Medical Service must have been relatively attractive — a regular salary, even if quite low, was better than none — but that is far from saying that the salary was in itself an attraction of medical work in the colonies. On the contrary, pay was mostly portrayed as being uncompetitive, especially relative to the difficult local conditions and the level of expertise required. This section examines how the home economic situation in the pre and post-World War One period stimulated Colonial Medical Service recruitment in different ways and discusses the influence of Service pay.

* * *

Many medical historians who have researched the dynamics of medical employment in the Victorian and Edwardian periods have pointed out that professional market pressures at home were among the most significant forces acting upon doctors taking up an imperial medical posting. Douglas Haynes, building on work on the English medical profession by Anne Digby and Jeanne Peterson, strongly reinforced the idea that professional overcrowding at home after 1850 created a medical market that was increasingly competitive. By the 1880s and 1890s this had become acute enough to cause many doctors to look for alternative ways of making a living — one of which

was in the newly expanding Empire.⁸ In the context of this increasingly competitive environment, the Colonial Medical career offered an attractive option for medical graduates in need of a stable and assured salary. Furthermore, the growth in the medical market at home had brought certain other pressures. Doctors who had obtained domestic employment often found that they were not necessarily guaranteed the prosperity they had expected from the profession. Increasingly, therefore, the Colonial Medical Service became seen as an alternative for practitioners faced with the difficult reality that “passing an examination is one thing, finding a subsequent job is another”.⁹ Anne Digby has examined these conflicting tensions in meticulous detail. On one hand, the medical profession at the end of the nineteenth century had established itself as a viable and interesting career, but on the other it was very crowded and did not necessarily bring large financial rewards.¹⁰ Despite doctors’ claims to gentility and social prestige, the reality of medical life, Digby persuasively concluded, was that, for most practitioners, it was rather difficult to ‘make a medical living’ in Great Britain.¹¹ Even Samuel Squire Sprigge, who tended to minimise the importance of medical overcrowding in his assessment of the problems medicine faced in 1905, acknowledged the competition for practices and patients and had to admit that the “grievances of the general practitioner are very substantial”.¹²

⁸ DM Haynes, *Imperial Medicine: Patrick Manson and the Conquest of Tropical Disease*, Philadelphia, PA, 2001, p.7, pp.15–18; MJ Peterson, *The Medical Profession in Mid-Victorian London*, Berkeley, CA, 1994, pp.124–6; A Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720–1911*, Cambridge, 2002 [1994], pp.144–7; A Digby, ‘A Medical El Dorado? Colonial Medical Incomes and Practice at the Cape’, *SHM*, 8, 1995, pp.463–79; Haynes also explores the issue of an overcrowded British medical marketplace at the end of the nineteenth century in DM Haynes, ‘Social Status and Imperial Status: Tropical Medicine and the British Medical Profession in the Nineteenth Century’ in D Arnold (ed.), *Warm Climates and Western Medicine: The Emergence of Tropical Medicine, 1600–1900*, Amsterdam, 1996, pp. 208–220

⁹ Gerald Gerry states this as his rationale in taking a job as surgeon on a steamer to West Africa c. 1885. TG Garry, *African Doctor*, 1939, p.24. Haynes also makes this point when describing the young Manson’s decision to join the Imperial Maritime Customs Service: “Excellence at medical school did not translate into career success in Aberdeen or England”. Haynes, *Imperial Medicine*, p.16

¹⁰ An early survey conducted by James Paget in 1869 of St Bartholomew’s Hospital Medical School found that “for a variety of reasons, not all of them economic, many of these élite entrants had failed to make what was considered a fair living from their profession. Twelve per cent had had only limited success in practice, six per cent had failed entirely, and ten per cent had left the medical profession”. J Paget, ‘What becomes of Medical Students?’ *St Bartholomew’s Hospital Reports*, 5, 1869, p.238 cited in Digby, *Making a Medical Living*, p.161

¹¹ *Ibid.*

¹² S Squire Sprigge, *Medicine and the Public*, 1905, p.49

The pressure on medical jobs was particularly acute for Welsh, Scottish and Irish doctors. Their problems were often compounded by their comparative lack of access to the prerequisite capital or connections enjoyed by their wealthier English colleagues. Doctors qualified in England were more highly regarded by potential employers, even though theoretically those trained in Scotland, Ireland or the provinces held qualifications of equal professional status. Up until the Great War, a certain amount of snobbishness still afforded priority to English candidates who had a qualification from the Royal College of Surgeons or the Royal College of Physicians of England.¹³ The difficulty in obtaining post qualification employment in Britain — allied to the rising output of doctors from provincial medical schools — goes some way towards explaining the existence of a large Celtic contingent within the Colonial Medical Service. Certainly, Scottish and Irish educated doctors joined the Colonial Medical Service in quite large numbers throughout the period: 225 (well over half of the doctors included in the prosopography), received all or part of their medical education in Scotland or Ireland (see Chapter 5).

Although almost uniformly characterised as comparatively poorly paid, a Service career offered relative professional independence within the stable framework of an organised civil service with prospects for promotion and advancement as well as reasonable pension rights. These attractions could have been particularly important to the less well-off middle classes who were increasingly going through medical schools, but who did not have the capital to establish themselves in private practice. Hugh Trowell, for example, admitted that as a “scholarship boy with no private means” his options for a medical career in 1929 were seriously curtailed, as he could neither afford to go into private practice nor work in hospital.¹⁴

The idea that the domestic economy was a primary factor driving medical career decision-making can be also sustained for the post war period. Although the medical profession continued to grow after the war vacancies were created in the home profession through war fatalities and the growth of opportunities for doctors

¹³ Haynes, *Imperial Medicine*, p.18

¹⁴ RHL/MSS.Afr.s.1872/144b HC Trowell, interviews, tape 1B, [n.d. c.1984]; see also similar comments for the pre-war period RHL/MSS.Brit.Emp.r.4, PA Clearkin, *Ramblings and Recollections of a Colonial Doctor 1913–58*, Book I, Durban, 1967, pp.14–15

within the public and military services as well as within business and commerce, which offered increasingly competitive salaries. Although the growth of the medical profession continued to be publicised in the medical press, the pressures on the home market were reduced and doctors subsequently were more easily accommodated within the United Kingdom. Applications to the Colonial Medical Service went down correspondingly.¹⁵ The increased presence of women in the medical job market, particularly after the First World War, made little difference to Colonial Medical Service recruitment, because of the inherent bias towards accepting men which continued until the end of the period.¹⁶

Similarly, the major downturn in medical service recruitment that occurred after 1935 can be interpreted as having been chiefly led by the market forces at home. During the depression in the early 1930s it again became more difficult for doctors to find work in the domestic market, but when times became better, and employment chances for doctors at home improved, recruitment to the Empire Services dropped off.¹⁷ Dr Arthur O'Brien, the Chief Medical Adviser to the CO, specifically attributed the improved conditions for medical practice in the United Kingdom and increased competition from other medical services as factors in the colonial medical recruitment slump of the late 1930s.

There is no unemployment amongst the medical profession at present in Great Britain. The public medical services (municipal and country) in this country have expanded very much during the last few years and prospects for these services have been improved for the average Medical Officer with a little capital and prospects in General Practice at present are distinctly good.¹⁸

Economic issues were insufficient to account for the ups and downs of recruitment. Sometimes boom periods, such as that experienced in the late 1920s, occurred when

¹⁵ 'Numbers of the Medical Profession', *BMJ*, ii, 1931, pp.418–19, p.418; also 'The Portal of Medicine', *Lancet*, i, 1936, pp.672–3

¹⁶ For information on the growth of medical opportunities for women see TN Bonner, *To the Ends of the Earth: Women's Search for Education in Medicine*, Cambridge, MA, 1992; TN Bonner, *Becoming a Physician, Medical Education in Britain, France, Germany and the United States, 1750–1945*, Baltimore, 2000 [1955], pp.312–15

¹⁷ "[t]wo years ago it was difficult for a young medical officer to find employment in this country but the reverse holds today [1936]. I believe there is an actual shortage of medical men for the present". PRO/CO/850/71/9 Minute: AJ O'Brien, 'Colonial Medical Service Recruitment', 08/02/1936

¹⁸ PRO/CO/877/16/16 Minute: AJ O'Brien, Chief Medical Adviser to the CO, 07/06/1938

the home market was also buoyant.¹⁹ While there is no exact correlation with periods of increased interest in the Colonial Medical Service it often happened at times of increased professional pressure on doctors at home.

Of course, more personal issues also surrounded conscious choice. A sensible candidate to any profession would make a thorough assessment of the overall economic climate future prospects. The backdrop of fluctuating supply and demand at home would clearly play a part, but for most people the daily economic influences on choice boiled down to a question of how much they were to be paid. It is perhaps a testament to just how bad conditions were elsewhere and how good perks of the career were perceived to be that despite a perception that pay was poor, applications to the Service far outstripped available positions before World War One and during the second half of the 1920s. Not all officers thought that the starting salaries were inadequate. Arthur Boase felt that £600 a year “seemed like a lot of money”, when he was taken on in 1924²⁰, but in general, the salary was thought to be uncompetitive, given the dangers, stresses and expertise integral to the job.

Compared to what newly qualified doctors could expect to receive as a houseman, however, salaries were a significant improvement.²¹ Peter Clearkin, who came from a large Irish Catholic family with limited financial means, recalled that he had to choose his post-qualification hospital residency carefully because some simply did not pay enough for him to survive without parental help. After only four months as a houseman financial considerations forced him to move to private practice and it was only after it became clear that this did not suit him either that he decided to apply for the Colonial Medical Service in 1913.²² Although Clearkin complained that the Colonial Medical Service pay “could not by any stretch of the imagination be called generous”, the salary he would have received from the Colonial

¹⁹ In this case the surge occurred largely because of the CO’s concerted medical recruitment drive coupled with the increased popularity of Empire careers.

²⁰ RHL/MSS.Afr.s.1872/16 A Boase (compiled, RM Boase), ‘Notes on Experiences in Colonial Medical Service in Uganda, 1924–56’, 14/02/1983, p.1

²¹ P Holden, *Doctors and Other Medical Personnel in the Public Health Services of Africa, 1930–1965*, Oxford, 1984, p.2

²² RHL/MSS.Brit.Emp.r.4, Clearkin, *Ramblings and Recollections*, Book I, pp.14–15

Service was still considerably more than the (£125 per annum) that he had received as a young assistant in private practice a few months before.²³

Farnworth Anderson recollected a similarly frugal state of affairs during his period as a houseman in the early 1920s:

All we could hope for was two or three guineas occasionally for assisting one's chief with an operation on a private patient in a nursing home. One's chief came in three or four times a week....The rest of the time you had to look after the patients and to supervise the work of the dressers on the firm, write to patients to come in to hospital, see return out patients, and of course to assist in any operations. Occasionally I was allowed to do an operation if my chief was feeling indulgent and satisfied with my capabilities.²⁴

Although colonial salaries were better than those that doctors could generally expect to receive immediately after qualification, it should be remembered that the Colonial Medical Service preferred to recruit doctors who had already had a couple of years hospital experience (see Chapter 2). Some officers did manage to join straight after qualification, but most considered the career only after having completed a hospital residency. It is by comparison with typical post-residency salaries that colonial medical pay was viewed as low.

During the entire period under consideration, the starting salary for Colonial MOs was only once raised. Between the beginnings of the Colonial Medical Service in East Africa and April 1920,²⁵ a new MO could expect to receive £400 or, after 1910, £500 per annum²⁶, compared to a share in a private practice in Great Britain in 1909 that paid £1,000 per annum.²⁷ The situation clearly caused grievances among the officers themselves; in 1918 East African colonial doctors Henderson, Massey and Small complained to the BMA that the starting salaries in the EAMS had not

²³ *Ibid.*, p.15

²⁴ RHL/MSS.Afr.s.1653, TF Anderson, *Reminiscences by T Farnworth Anderson*, Book I, Kenya, 1973, p.12

²⁵ BMA/B/162/1/8 'New Scale of Salaries Proposed by the Colonial Office to be Brought into Effect, 01/04/1920', Dominions Committee Documents, Session 1920-1

²⁶ PRO/CO/543/1 EAP Bl.Bk., 1901-2; PRO/613/1 UP Bl.Bk., 1901-2; JL Gilks 'The Medical Department and the Health Organization in Kenya, 1909-1933', *EAMJ*, 9, 1932-3, pp.340-54, p.342

²⁷ Digby, *Making a Medical Living*, p.132

increased since the turn of the century.²⁸ And even when the rate of colonial pay was finally updated to £600 per annum (the rate at which it remained until the end of the period), it was not long before this too was perceived as being out of keeping with inflation and analogous salary rates in other medical jobs.²⁹ A comparison put forward by the Director of Medical and Sanitary Services (DMSS), Sierra Leone, JCS McDouall, 1931 is indicative. To support his argument that the low colonial salary was at the heart of recruitment problems, McDouall included several job advertisements for public medical appointments that he had found in the *BMJ*. These showed that the position of Assistant School MO and MOH in the County Borough of Blackburn was offered a starting salary of £600 p.a.; a job at the County Bacteriological Laboratory in Staffordshire started at £700 p.a. and Deputy MO of Health and Assistant School MO for Caernarvonshire County Council also offered a starting salary of £700 p.a.³⁰ Plainly, colonial salaries were uncompetitive compared with other positions opening up for British doctors.

The very vocal complaints about salaries made on behalf of the British medical profession by the BMA peaked in 1920.³¹ The CO was sufficiently worried to put some effort into publicly justifying the pay scales; in organised talks to medical schools from the 1920s onwards. Andrew Balfour, in a enthusiastic address calling medical students to consider the opportunities offered by a Colonial Service career, had to admit that salaries could be described only as “fairly satisfactory” (something, he playfully commented, Scotsmen—such as he was addressing—would find particularly hard to swallow).³² Several years later the apologetic tone remained; Charles Jefferies in his book on the Colonial Service that offered advice to the potential recruit was at great pains to justify the salary that MOs could expect to

²⁸ BMA/B/162/1/6 Letter: Drs Henderson, Small and Massey to the BMA Dominions Committee, (Session 1918-19), 16/12/1918

²⁹ This is indicated by the way official literature sought to justify the salary. *Colonial Service Recruitment No.3: Information Regarding the Colonial Medical Service*, 1935, p.13; see also C Jeffries, *The Colonial Empire and its Civil Service*, Cambridge, 1938, p.110

³⁰ PRO/CO/850/12/13 Memorandum: JCS McDouall, [DMSS, Sierra Leone] to Colonial Secretary, 19/10/1931

³¹ ‘Memorandum of Evidence Placed by the BMA before the Colonial Medical Services Committee (Appointed in November 1919), on 23rd February 1920’, *BMJ, Supplement*, 1920, pp.141–3, p.143

³² A Balfour, ‘Vistas and Visions: Some Aspects of the Colonial Medical Services’, *GMJ*, 6, 1924, pp.353–74, p.355

receive. Potential candidates were reminded that the post bought with it considerable and generous benefits, such as free or subsidised housing, healthcare and passages as well as a non-contributory pension provision. The overall package meant that the “‘real wages’ of an appointment are very substantially more than the salary would suggest”.³³ By 1939 the Assistant Medical Adviser to the CO was confident that the career choice offered a “comfortable”, although not luxurious, living for the officer and his dependents.³⁴ The other perks, not least the reduced costs, meant that officers could hope to live “in a style that he could not hope to maintain in this country”.³⁵

Clearly doctors joined the Colonial Service not only because there were few other alternatives available to them; indeed, some newly qualified doctors were attracted to the career over alternative options for gainful employment. Examples from both the early and later periods show that ultimately the poor salary was not always enough to deter people. Arthur Bagshawe was said to have shunned the offer from his uncle to join him in his large private practice in Sussex, in favour of deciding his own path and taking a job in the Colonial Medical Service.³⁶ And Arthur Williams caused his father “sad disappointment” when he made a similar decision in the early 1930s and refused the offer to join the large family country practice in Northumberland.³⁷

Different economic dynamics affected recruitment patterns in different periods. Whereas attractive salaries might persuade doctors to stay at home, especially in times of domestic economic difficulty, this was not always the case. Despite a language of justification and explanation that characterised official commentaries on the issue, the career clearly offered opportunities that were more substantial than that which was represented solely by the yearly salary rates. To see why doctors went to East Africa, these other factors should be given due assessment.

³³ Jeffries, *Colonial Empire*, p.110

³⁴ Smart, ‘An Impression of Life in the Colonial Medical Service’, p.123

³⁵ *Ibid.*, p.125

³⁶ ‘Arthur Bagshawe’, *Lancet*, i, 1950, pp.693–4; p.693

³⁷ RHL/MSS.Afr.s.1872/153a AW Williams, ‘Detailed Memoranda on Experiences in the Colonial Medical Service in Uganda and Tanganyika, 1931-1949’, [n.d. c.1983], p.1

3.2 Practical Considerations and the Social Factor

There were four main reasons why doctors may have chosen the Colonial Service career route: first in accordance with CO assurances, the overall remuneration *package*, was an opportunity for financial security, if not prosperity; second, the career was comparatively easy to get into and was quite well advertised in a respected forum (the *BMJ*) especially compared to other Colonial Service careers that were mostly completely unadvertised throughout the period; third, the need for a medical qualification made it intrinsically more meritocratic in that it was open to a larger portion of the middle classes than, for example, the CAS (which still looked primarily to Oxbridge and the public schools as markers of suitability); last, the Colonial Medical Service offered a respectable governmental career that had enough prestigious associations to confer some social respectability, even if it did not have the equivalent status of the Indian or Sudan Medical Services.

A posting in East Africa was particularly attractive because the region was regarded as climatically healthier than West Africa.³⁸ This not only made the EAMS more directly appealing, but meant that it was more feasible for young doctors to take their wives and families with them on a first posting. Although these factors were quite unexceptional, they all contributed to what may be called the practical attractions of the colonial medical career.

* * *

Even if the salary cannot have been a particular inducement to a Colonial Medical career the whole package of the job offered some benefits. The cost of living in the colonies was substantially less than at home, officers did not have to pay income tax in East Africa and the job provided free living quarters, paid passage, financial provision for widows and orphans, a non-contributory pension scheme and the opportunity to supplement pay, if it was desired, through private practice. Most important, especially during difficult economic periods at home, was the promise of

³⁸ It was due to the "unhealthiness of the climate" that positions in WAMS were higher paid and on better terms than in other parts of Africa, 'Information as to Colonial Appointments', *CO List*, 1899, pp.346-8, p.347

regular monthly pay, with annual increments and fixed steps to promotion.

“[C]ertainty” emphasised one Colonial Medical Service selector, rather than any other incentives (including “extra emoluments”) was what “the majority of candidates expect to find in the government service”.³⁹ To some the idea of a fixed tenure of employment, once they had completed the probationary period, was a real draw to the career and some hoped that they would remain in the Service for the rest of their working lives.⁴⁰ On the other hand, although the stability offered was attractive, it was sufficiently flexible for doctors to leave the career if it did not agree with them or their families. The promise of a gratuity after the prerequisite service requirement of ten years no doubt added to the Service’s relative desirability. In fact, it is difficult not to see some relationship between the average length of service for doctors in East Africa, which was eleven years, and the fact that ten years was the minimum length of service needed to qualify for the gratuity.⁴¹

Another practical consideration that may have affected some of the entrants’ decisions was that an appointment into the Colonial Medical Service was relatively easy to secure when compared to the highly competitive entrance examinations that both the Army and the IMS required.⁴² Both of these examinations were followed by mandatory six-month instruction course — much longer than that which was required to achieve the DTM&H needed by Colonial Medical Service entrants after 1899.⁴³ This reason for entering the Service is not mentioned in memoirs or obituaries, but this is not surprising as it would be unusual for any candidate to admit ‘ease of entry’ as a reason for choosing a career, not least because it would portray the individual as being unambitious (or worse, aware of their intellectual limitations) and

³⁹ RHL/MSS.Brit.Emp.s.415, Furse Papers, Memorandum: Furse to Lord Milner, 18/06/1918 [Original italics]

⁴⁰ RHL/MSS.Afr.s.1872/16 Boase, ‘Notes on Experiences’, p.1

⁴¹ Calculated from the prosopography.

⁴² Apparently physical examinations for the IMS were more stringent too. Clare Wiggins recollected that he applied to the Colonial Medical Service because he was too short-sighted for the IMS. CA Wiggins, ‘Early Days in British East Africa and Uganda’, *EAMJ*, 37, 1960, pp.699–708, p.699

⁴³ Indian Service and Army Service training was initially conducted at Netley (opened 1863), although after 1902 all army medical training moved to Milbank and after 1905 (when Netley was closed) prospective IMS officers went to LSTM to prepare them for their careers. Similar training was required at Haslar for candidates for the Naval Medical Department. P Manson-Bahr, *History of the School of Tropical Medicine in London: 1899-1949*, 1956, p.22

would imply a lower status to the career. Although there is no explicit evidence for this factor it is likely to have been at least a subconscious motivation in some cases. After the demanding examinations that doctors needed to pass in order to qualify, the prospect of another test would be very unappealing.⁴⁴

Despite Andrew Balfour's bitter complaint in 1924 of "lamentable ignorance" among medical graduates about the possibility of a government medical career in Empire, it was relatively easy to hear about the career as a young medical graduate.⁴⁵ Not only had there been a concerted campaign since the mid 1920s to promote the career in lectures to medical schools, it was one of the few Colonial Service careers that regularly advertised. Several doctors mention that an advertisement in the *BMJ* prompted their application.⁴⁶ Also (see below) as the period progressed it became increasingly easier to obtain detailed information on the tropical world. As well as popularising Africa more generally in the public imagination, this allowed young men to judge whether a tropical career would suit them. Throughout the period prospective candidates could get further information on the life, climate and living expenses of the colonies from an ever-expanding literature of handbooks and travel advice manuals.⁴⁷ Government publications had been available since the 1880s and the CO published an information booklet specifically for Colonial Service candidates from 1930 onwards.⁴⁸ Information for candidates for East Africa could also have been obtained from HM Eastern African Trade and Information Office in London.⁴⁹

East Africa held specific appeal because it seemed a relatively healthy option, especially when compared to West Africa. Of course, the difference was only

⁴⁴ The fact that Furse admitted that the Medical Service was not always staffed by the most outstanding candidates gives weight to the ease of entry factor. Eg, RHL/MSS.Brit.Emp.s.415, Furse Papers, Furse, 'Confidential No.38: Recruitment and Training of Colonial Civil Servants', CO Conference, 1927, p.11

⁴⁵ Balfour, 'Vistas and Visions', p.354

⁴⁶ RHL/MSS.Afr.s.1872/75 RS Hennessey, 'Learning About Disease in Uganda: 1929-44 and 1949-55', 1983, p.3; RHL/MSS.Afr.s.1872/82 JK Hunter, 'Detailed Memorandum on Experiences in the Colonial Medical Service in Uganda, 1939-58', [n.d. c. 1983], p.3

⁴⁷ Eg, JB Purvis, *Handbook to British East Africa and Uganda*, 1900; HF Ward and JW Milligan, *Handbook of British East Africa*, 1912-13, 1913

⁴⁸ *Colonial No.56: Information as to the Conditions and Cost of Living in the Colonies, Protectorates and Mandated Territories*, 1930; Eg, KNA/MOH/1/2646 *Emigrant's Information Office, General Information as to the Uganda Protectorate*, 1904

⁴⁹ Sources of further regional information were listed in *Colonial Service Recruitment No.3*, p.14

relative. Clare Wiggins related the story of his entrance interview (c.1900) when he was told in response to an enquiry over pension terms: “[p]ension, *pension*, Good Heavens, boy, no one lives to draw a pension!”⁵⁰ But East Africa was certainly seen as safer. Arthur Williams turned down an offer of a posting in Nigeria because of its reputation as ‘white man’s grave’ before taking one to Uganda, which he thought a rather safer option.⁵¹ Hugh Trowell too declared that he had been quite put off by the “rather grim stories about West Africa” and had therefore quite consciously decided that he would wait for a posting in East Africa, especially as he hoped to have a family with his wife there.⁵²

The prospects of a healthy environment for Europeans must have been particularly persuasive to doctors, a group with a professional interest in debates surrounding matters of health. In the earlier part of the period discussions over the suitability of Europeans to long-term residency in the tropical world frequently featured in the medical press. Medical orthodoxy emphasised the fundamental inability of Europeans to acclimatise as one of the strongest obstacles to settlement, but doctors such as Luigi Sambon challenged these notions.⁵³ The old views became replaced by a new faith in (tropical) medical science, particularly in the benefits of public health measures that allowed Europeans successfully to survive in hot and unwholesome places. Gradually the image of Africa as ‘white man’s grave’ gave way to cautious optimism: the tropics needed to be managed through special precautions and routine, but this management was quite possible. Some of the negative health images — particularly an enduring view that women and children were not suited to long term residence⁵⁴ — remained throughout the period, but perceived risks receded

⁵⁰ No source given, quoted in DF Clyde, *History of the Medical Services of Tanganyika*, Dar Es Salaam, 1962, p.104

⁵¹ RHL/MSS.Afr.s.1872/153a Williams, ‘Detailed Memoranda’, p.1

⁵² RHL/MSS.Afr.s.1872/144b Trowell, tape 1B

⁵³ L Sambon, ‘Remarks on the Possibility of the Acclimatisation of Europeans in Tropical Regions’, *BMJ*, i, 1897, pp.61–66

⁵⁴ Keeping school-age British children in Africa was officially advised against as late as 1936 *Colonial Service Recruitment No.1: The Colonial Service, General Information Regarding Colonial Appointments*, 1936, p.52

in the public and medical imagination from 1900 onwards.⁵⁵ CO publications actively promoted the climatic advantages of the Eastern region; descriptions of the highlands of Kenya stressed familiarity rather than any unusualness.⁵⁶ For Africa in general Europeans needed to take “elementary precautions” (and trips back to the United Kingdom), but this was far removed from earlier ideas that questioned the suitability of Europeans for any lengthy periods of residency in the tropics at all.⁵⁷ By the Edwardian years the pessimism of the late nineteenth century was almost entirely replaced with optimism based on the successes of tropical medicine in improving the prospects for long-term European settlement in the tropical world.⁵⁸ Indeed colonisation was presented in some forums as a way to further the boundaries of medical science by making areas more habitable.⁵⁹

Closely associated with this idea that the climate of the East of Africa was more favourable than that in other colonial postings were the considerations doctors had for their wives and families. Many doctors mentioned that the East African Service appealed to them particularly because it meant that they could take their wives with them. Arthur Cole took the Colonial Service option over his preferred career in the Sudan Medical Service principally for this reason.⁶⁰ Robert Hennessey made a similar point.⁶¹ Similarly, Arthur Williams preferred a Colonial Service career to becoming a missionary in 1931 because he thought that the latter would not allow him to have a wife.⁶²

To add to these considerations was the appeal of a government position as a marker of social respectability. As the period progressed and public pride in the

⁵⁵ P Curtin, ‘The White Man’s Grave: Image and Reality, 1780–1850’, *JBS*, 1, 1961, pp.94–110; P Curtin, *The Image of Africa: British Ideas and Action, 1780–1850*, Madison, 1964; P Curtin, ‘The End of ‘White Man’s Grave’? Nineteenth-Century Mortality in West Africa’, *JIH*, 21, 1990, pp.63–88

⁵⁶ Kenya Highlands were said to have “a climate not dissimilar to a fine English summer” *African (East) No.1105: Information for the Use of Candidates to Appointments in the East African Medical Service*, 1925, p.6

⁵⁷ *Colonial Service Recruitment No.1*, p.8, p.51

⁵⁸ Anon, ‘The White Man in the Tropics’, *BMJ*, ii, 1911, pp.759–60

⁵⁹ Anon, ‘Medical Science and Colonization’, *BMJ*, i, 1905, pp.1002–3

⁶⁰ RHL/MSS.Afr.s.1872/33 ACE Cole, ‘Memorandum on Experiences in the Colonial Medical Service in Tanganyika, 1939–60’, 10/04/1983

⁶¹ RHL/MSS.Afr.s.1872/75 Hennessey, ‘Learning About Disease in Uganda’, p.4

⁶² RHL/MSS.Afr.s.1872/153a Williams, ‘Detailed Memoranda’, p.1

British Empire rose, the colonial career gained kudos and a more favourable reputation. This was something that Furse had been keen to nurture. He articulated this quite conscious goal that he had held throughout his tenure:

Above all, the prestige of the Colonial Service must be raised in the eyes of potential candidates, and of their parents and advisers. The Service must be 'put on the map', and a woefully ignorant public made to appreciate the scope and variety of its achievements, and to realize that it offered one of the most interesting and spiritually rewarding careers open to the cream of the country's youth.⁶³

Furse must have felt satisfied at the end of his career in 1948 that all branches of the Colonial Service had grown in size and repute. Yet his vision was an essentially conservative one, based on the rank and behaviour of the ruling classes and the retention of essentially feudal ideas of ownership and management. By supporting methods and policies that complied with his "unashamedly rural, hierarchical and nostalgic" vision,⁶⁴ Furse naturally turned his back on the modern ideals of egalitarianism, and gender and racial equality that emerged in the 1930s.⁶⁵

If a medical training was (as one East African MO called it) a route to a "rational choice of career" which conferred respectability upon its members as a learned and established profession, its public status was heightened even further through the explicit and implicit associations that a governmental position held with the standards and attitudes of the ruling classes.⁶⁶ Furthermore, in the colonies, where health was at a premium, being a doctor was a particularly high profile community position, perhaps even more so than in Britain. As the following quotation illustrates, taking up a Colonial Service career meant that the increasing number of middle class medical graduates could expect to share some of the social

⁶³ R Furse, *Aucuparius: Recollections of a Recruiting Officer*, Oxford, 1962, p.62

⁶⁴ D Cannadine, *Ornamentalism: How the British Saw Their Empire*, Harmondsworth, 2001, p. 69

⁶⁵ Such as the new questioning of imperialism emanating from the Communist Party and the Independent Labour Party. For brief overview see D Kennedy, *Britain and Empire, 1880-1945*, 2002, p.74

⁶⁶ RHL/MSS.Afr.s.1872/75 Hennessey, 'Learning About Disease in Uganda', 1983, p.2

privileges they might otherwise not have had opportunity to experience in their home country:⁶⁷

[A]n officer of the Colonial Service can enjoy in many ways a higher standard of living than would be possible on a similar salary in this country. He can command much more in the way of personal service though the service may not be the most efficient. He has a definite rank and social position and does not, outside his office, become merely one of the crowd.⁶⁸

One closely related argument that has been put forward — most recently by David Cannadine — was that the Colonial Service career held appeal precisely because many class elements of the colonial lifestyle echoed the values of a bygone era of British landed society; one that was, furthermore, becoming increasingly untenable at home owing to the effects of urban growth, industrialisation and commercialisation.

As the metropolis became ever more urbanized and democratized, and its social fabric correspondingly decayed, these faraway societies, with their traditional hierarchies still intact, not only became more appealing, they also needed protecting from the very same forces of modernity that were destroying a traditional Britain.⁶⁹

This idea is not just a theory imposed retrospectively by historians keen to rationalise behaviour;⁷⁰ much of the promotional literature produced at the time stressed the way Eastern Africa particularly could offer conditions suitable for those with conservative, landowning, rural overlord ideals that were no longer as easily attainable in the western world.⁷¹ One Colonial Medical Service doctor recalled his

⁶⁷ Harriet Deacon has argued that one of the attractions of the Cape during the early nineteenth century was that doctors could secure greater status and broader professional opportunities there than they could at home. H Deacon, 'Cape Town and 'Country' Doctors in the Cape Colony During the First Half of the Nineteenth Century,' *SHM*, 1997, 10, pp.25–52

⁶⁸ Jeffries, *Colonial Empire*, p.125

⁶⁹ Cannadine, *Ornamentalism*, p. 67

⁷⁰ For the way a new tradition was invented for the African context see T Ranger, 'The Invention of Tradition in Colonial Africa' in E Hobsbawm and T Ranger (eds.), *The Invention of Tradition*, Cambridge, 2002 [1983], pp.211–62. Some of these ideas contributed to the construction of a specifically Colonial medical identity (Chapter 5)

⁷¹ Furse articulated this idea that "the man with the 'country gentleman's' or 'yeoman farmer's' background and traditions; the man who had an interest in peoples of a primitive type, their arts and handicrafts and customs, was often particularly suited to the work of the Colonial Service". PRO/CO/877/16/15 'Record of a Meeting of the Public School's Career's Association', 19/05/1938; see also Lord Cranworth, 'The Public School Boy in East Africa', *Nat.Rev.*, 336, 1911, pp.992–1000; Kuklick also makes this point in her description of career motivation for the CAS, H Kuklick, *The Imperial Bureaucrat: The Colonial Administrative Service in the Gold Coast, 1920–1939*, Stanford, CA, 1979, p.28

“early horror of the peri-urban industrial housing sprawl” he encountered on his train journeys to and from medical school, as being one of his leading incentives to practice medicine in Africa rather than remain in his home country.⁷² In the same way, contemporary concerns, particularly present in Kenya, over the issue of ‘poor whites’ entering the country seemed to further reflect a desire to preserve, if not a real ruling elite, certainly one that espoused its values.⁷³

Aside from the social prestige that a governmental position conferred on Colonial Officers, a job in the Colonial Medical Service offered social benefits that doctors were unlikely to have been guaranteed at home. In the colonies an MO was a member of a small and exclusive ruling elite, who could expect to have servants and other accoutrements of his newly acquired status.⁷⁴ The lifestyle offered a “much freer existence”, than that which existed in the home country, not least because the Colonial Service was mostly staffed with young people.⁷⁵ Perhaps even more persuasively, the life was presented as fun. Colonial communities, although scattered, could usually converge on a central social club that typically held dances and other collective events. Thus, one travel guide recommended that those travelling to East Africa should bring formal evening wear to wear at the club in Mombassa.⁷⁶

Even the smallest station boasts a club where people gather in the evenings for a game of lawn tennis and a drink at sundown. In the larger stations, there are, of course, greater facilities for recreation, including polo and golf. There is also some measure of social life, and officers’ wives live active and happy lives.⁷⁷

First and foremost it was a place attractive to outdoor types: “anyone whose interests lie in the direction of art, music or literature, may expect to find his opportunities

⁷² RHL/MSS.Afr.s.1872/153a Williams, ‘Detailed Memoranda’, p.1

⁷³ D Hall, ‘Settlers’ Problems in Kenya’, *JRSA*, 78, 1930, pp.406–23; E Brodhurst-Hill, *So This is Kenya!*, 1936, p.2

⁷⁴ Smart, ‘An Impression of Life in the Colonial Medical Service’, p.125; also E Trzebinski, *The Kenya Pioneers: the Frontiersmen of an Adopted Land*, 1991 [1985], p.63

⁷⁵ Smart, ‘An Impression of Life in the Colonial Medical Service’, p.125

⁷⁶ “...two black silk bow-ties. For dinner wear. Not made up ‘shyster’ ones” A Field, ‘*Verb. Sap.*’ *On Going to East Africa: British Central Africa, Uganda and Zanzibar and Big Game Shooting in East Africa*, Vol. 2, 1906, p.12

⁷⁷ PRO/CO/877/13/8 Clipping: *The[Melbourne]Herald*, ‘Empire Careers for Australians’, 13/03/1936

for such pursuits restricted”.⁷⁸ Not only, said Lord Cranworth, were there abundant opportunities to hunt “some of the finest game animals in the world” but “bird-shooting is almost everywhere good” and fishing was “generally obtainable.” Group sports were frequently played: Cranworth seemed to think that prospective inhabitants would be hard pushed to find themselves so far away from a station that they would have to miss out on lawn tennis or “the occasional game of cricket”.⁷⁹ Furthermore, others declared that “...the general standard of play in games is considerably higher than that found at home”.⁸⁰ This was because of the natural place sports had as part of the “routine of living and have a prominent place in the station life”.⁸¹ Harrison has acknowledged this emphasis on the attractions of the sporting life in his work on the IMS. Most famously Ronald Ross’s initial choice of posting to India seemed to have been closely connected to his desire for adventure: “[i]t was only late in his Indian career that Ross acquired an interest in scientific research and in public health. The recreational activities which attracted him to the IMS also loom large in the diaries of other Medical Officers stationed in India; often to the exclusion of any detailed description of medical practice”.⁸²

It is debatable whether these images were accurately reflected the realities of tropical colonial life, which must have regularly been isolating, alien and characterised by the lack of home comforts. However, the perception of colonial life projected by these positive images *did* clearly influence doctors’ choices.⁸³ Arthur Warriner Williams turned down an initial job offer in the WAMS in Nigeria, because he felt that (as well as being more deadly) the place offered fewer opportunities for big-game hunting.⁸⁴ Philip William Hutton reminisced that he had been attracted to Uganda, not only because the medical school there offered opportunities to teach, but also because of the sport, especially sailing, offered by the close proximity of

⁷⁸ Jeffries, *Colonial Empire*, p.125

⁷⁹ Cranworth, ‘The Public School Boy in East Africa’, p.996

⁸⁰ Smart, ‘An Impression of Life in the Colonial Medical Service’, p.125

⁸¹ *Ibid.*

⁸² M Harrison, *Public Health in British India: Anglo-Indian Preventative Medicine 1859–1914*, Cambridge, 1994, p.14

⁸³ For an analogous example of perceptions being deceptive see: Digby, ‘A Medical El Dorado?’

⁸⁴ RHL/MSS.Afr.s.1872/153a Williams, ‘Detailed Memoranda’, p.1

Lake Victoria.⁸⁵ John Buchanan was attracted by the sporting life too; he had enjoyed a successful rugby career (he was Scottish Rugby Captain in 1924) before and during his medical studies at Edinburgh University.⁸⁶

The colonial career, especially in East Africa, offered several attractions that doctors may have taken into account when making their career choices. These practical considerations included the overall employment package, the accessibility of the career, the comparative healthiness of the places to which they would be posted, the ability to take families with them, and the way the career also seemed to promise new recruits increased social standing and a dramatically improved lifestyle. With these advantages, it is hard to imagine why anyone should have wanted to stay in London. The way doctors often heard about these perceived advantages, through either word-of-mouth or family connections, played a crucial part in awakening this interest.

3.3 Connections

Although recruitment based on patronage was not officially in place after 1930 (Chapter 2), many of its fundamental tenets informed the actions and decisions of the Appointments Department well into the late 1940s. Personal recommendations, whether through a medical school Dean, a university liaison officer or a friend or relative who was already in the career (or a similar one), were vitally important both in terms of CO Officials hearing about good candidates and the applicants themselves hearing about the Service. Ralph Furse's policy of promoting the Colonial Service to medical graduates by the use of promotional talks by ex (or current) officers and CO officials would, it was hoped, attract the 'right' sort of candidates.⁸⁷ This time-honoured idea of 'leading by example' was similar to that traditionally employed within the hierarchical discipline and duty structures of public schools.⁸⁸ The

⁸⁵ RHL/MSS.Afr.s.1872/84 PW Hutton, 'Memorandum on Service as Physician Specialist, Acting Dean and Honorary Lecturer in Medicine, in Uganda, including Makerere, 1937–1961' [Feb.?] 1983, p.2

⁸⁶ 'John Buchanan', *BMJ*, ii, 1976, p.841

⁸⁷ PRO/CO/877/7/8 'Visit by Major Hutchinson to Scottish Universities and to Liverpool University to Encourage Recruits', 02/1930.

⁸⁸ Furse's approach is perhaps best encapsulated in a quotation in which he described recruitment via schools (for other branches of the Colonial Service): "We also sent Colonial Service officers on leave to

usefulness of close personal connections was acknowledged at the time. Medical school Deans recommended, for example, that talks by former medical students were better received than those given by people less intimately connected with the establishment.⁸⁹ The system did indeed seem to produce good results; by the 1930s Furse was satisfied that “the appointment of officers who were holding good public appointments in institutions has in many cases been found to lead to applications from their successors or colleagues”.⁹⁰ Not only were these publicity methods felt to be useful indicators of individual suitability; they were actively nurtured as an effective way of keeping up continuity and loyalty (the idea of a sense of tradition) to the Service.

There is no doubt as to the importance of personal influences upon MOs’ career choices. Even if this factor was not as strong as the economic one and Empire enthusiasm, it was frequently mentioned by the MOs themselves. The attractions of the career were publicised through medical families, personal or familial Colonial associations and information passed on about the Service career from friends and colleagues.

* * *

The importance of precedent, particularly as a guide to career choices in medical families during the nineteenth century, has recently been examined by historians.⁹¹ Crowther and Dupree have persuasively downplayed the importance of family succession in determining medical careers. Although they acknowledge the importance of having a medical parent as a potential guiding light into future career decisions, they prefer to emphasise networks of influence and patronage formed at

lecture to senior boys in many schools, choosing men who loved their work and were happy in the Service; where possible, too, men whose personality would attract the right type of boy. We wanted such a boy to say to himself ‘If that’s the sort of chap they’ve got in this service and he likes it, that’s the service for me.’” Furse, *Aucuparius*, p.224; R Wilkinson, *The Prefects: British Leadership and the Public School Tradition*, Oxford, 1964

⁸⁹ PRO/CO/877/7/8 Major Hutchinson, ‘Report on Visit to Scottish Universities and Liverpool University’, 07/04/1930

⁹⁰ RHL/MSS.Brit.Emp.s.415, Furse Papers, Memorandum: ‘On the Difficulty of Obtaining Candidates for the Colonial Medical Service’, 03/1931

⁹¹ H Marland, *Medicine and Society in Wakefield and Huddersfield, 1780–1870*, Cambridge, 1987; Peterson, *The Medical Profession in Mid-Victorian London*

medical school, as loose group markers and identifiers which usually persisted into later life.⁹² These findings are borne out by the examination of colonial medical identities (Chapter 5): doctors related particularly strongly to colonial colleagues who had been to the same university or medical school as themselves. A sense of group belonging was overlaid and extended by the particularities of the colonial setting. These felt connected through common purposes and expectations; what Dane Kennedy has labelled the “islands of white” of the colonial sphere.⁹³

Many Colonial MOs came from medical families.⁹⁴ Arthur Williams recalled how he had had an interest in life overseas but felt a “filial duty” to take over his father’s country medical practice; the Colonial Medical Service seemed to offer a way to reconcile both urges, especially as he confessed “an uneasy feeling of professional incompatibility” with his father and did not want to follow exactly the same career path as he had done.⁹⁵ Perhaps even more pertinent is the large number of MOs who had connections with Africa, or other colonial territories, through their families. Perhaps the most striking example is Philip Edmund Clinton Manson-Bahr, who joined the Colonial Medical Service in Tanzania in 1939: his famous grandfather was Patrick Manson and his father, Philip Manson-Bahr. As one obituarist pointed out, “this milieu exerted a significant influence on his future career”.⁹⁶

The importance of these factors with regard to recruitment into the IMS has also been acknowledged. Not only was a substantial proportion of recruits from medical families, but from colonial medical families, particularly those with Indian connections.⁹⁷ The relative newness of the EAMS meant that it was unlikely, at least until the end of the period, that East African doctors had parents in the same service (the IMS had been in existence in some form since the 1600s), but many had relatives

⁹² A Crowther, ‘Life Choices of British Doctors in the Late Nineteenth Century—Consultant or GP?’, paper given at the Wellcome Trust Centre for the History of Medicine at UCL, 13/11/2002

⁹³ D Kennedy, *Islands of White: Settler Society and Culture in Kenya and Southern Rhodesia, 1890–1939*, Durham, NC, 1987

⁹⁴ There are too numerous to mention but officers with a medical parent include Arthur Boase, Hugh Calwell, Arthur Cole; Graham Drury, Sidney Hinde, Aubrey Hodges, Alfred Mackie, Philip Manson-Bahr, Douglas Snell, John Shircore, Edwin Trim, Arthur Williams.

⁹⁵ RHL/MSS.Afr.s.1872/153a Williams, ‘Detailed Memoranda’, p.1

⁹⁶ ‘PEC Manson-Bahr’, *BMJ*, 314, 1997, p.609

⁹⁷ Harrison, *Public Health in British India*, p.29

with medical missionary or governmental medical service backgrounds.⁹⁸ Arthur Morley's father had been a medical missionary in China;⁹⁹ Arthur Cole referred to the "considerable overseas tradition in his family" as having influenced his decision to take up a colonial medical career. His grandfather and father had both been medical missionaries, in India and China respectively, and his wife's parents had served in Nyasaland in the early expeditionary days.¹⁰⁰ Alfred Mackie was born in Antigua in the West Indies where his father was a Colonial MO.¹⁰¹ Arthur Boase's father worked in the Medical Service of British Guiana, and accordingly felt that the Colonial Medical Service seem "the natural thing" to do after he had qualified.¹⁰² Some were sons of IMS officers: John Shircore's father had been an IMS captain,¹⁰³ as were the fathers of Herbert Duke¹⁰⁴ and Raymond Price.¹⁰⁵

It seems reasonable to attribute Ernest Cook's initial decision to join his famous uncles (Albert and John Cook) at Mengo in Uganda to family influences and expectations. Rather than remain a missionary, Cook transferred to the Colonial Service after 1926 (until 1936).¹⁰⁶ Farnworth Anderson decided to go to Kenya partly because his second brother had gone there before him and had "loved it".¹⁰⁷ Similarly, Albert Owen was attracted to his Colonial Service career through the experiences of his elder brother Hugh, in Uganda.¹⁰⁸ Brothers James and Percival Ross both took up medical careers in Kenya.¹⁰⁹ Although little is known about

⁹⁸ Although doctors could express a preferential posting in their applications they had little other control over which posting they would be offered. So doctors could not choose to be in the same colony as their friends or relatives with any certainty, unless, they were prepared to wait.

⁹⁹ 'Arthur Morley', *BMJ*, 295, 1987, p.220

¹⁰⁰ RHL/MSS.Afr.s.1872/33 Cole, 'Memorandum on Experiences'

¹⁰¹ 'Alfred Mackie', *BMJ*, ii, 1959, p.1262

¹⁰² RHL/MSS.Afr.s.1872/16 Boase, 'Notes on Experiences', p.1

¹⁰³ 'John Shircore', *Lancet*, ii, 1953, p.94

¹⁰⁴ 'Herbert Duke', *Who Was Who*, 1961-1970, Vol. VI, 1979 [1972], p.323

¹⁰⁵ DG Crawford, *Roll of the Indian Medical Service*, 1615-1930, 1930, p.498

¹⁰⁶ 'Ernest Cook', *BMJ*, i, 1959, pp.1049-50, p.1049

¹⁰⁷ RHL/MSS.Afr.s.1653, Anderson, *Reminiscences*, Book I, p.14

¹⁰⁸ 'Retirement Tribute', [to Albert Owen], *EAMJ*, 11, 1934-5, pp.363-4, p.363

¹⁰⁹ KNA/MOH/3/247 P Ross, P1(Med.), 1925

Robert and Victor van Someren, or the two Twinings they qualified around the same time from the same institutions and were probably related.¹¹⁰

Many Colonial MOs came from non-medical colonial backgrounds: William Kauntze descended from a famous Doctor of divinity, William Carey, “the well-known Oriental scholar, who had been one of the earliest missionaries in India”.¹¹¹ Dowdeswell and Ansorge were both born in Bengal;¹¹² Dawson Milne was born in Kingston, Jamaica;¹¹³ Robert Moffat, Mary Turton and Colin Carothers all came from South African backgrounds;¹¹⁴ John Buchanan was born to an early colonial family in Nyasaland;¹¹⁵ and Philip Hutton was born to colonists in India.¹¹⁶

Many officers joined the Colonial Service because they had been influenced by positive accounts of colonial life from relatives or friends. Charles Wilcocks sold his private practice and joined the Colonial Medical Service because of the enthusiastic reports of a friend in the Service.¹¹⁷ Arthur Cole recalled the positive influences of his brother-in-law who was a member of the Nigerian Medical Service.¹¹⁸ Raymond Barrett described how he was influenced in his future career while employed as an assistant in what he described as a “working class practice”; one of his bosses had previously worked for the Medical Service in Kenya and was an “ardent advocate” of the advantages of the colonial medical life.¹¹⁹ Similarly, Hugh Calwell decided on an overseas public service career after being impressed by a lecture by Sir John Megaw,

¹¹⁰ Although perhaps the Twinings were only related by marriage. MO Helen Twining was to marry the future Governor of Tanzania. D Bates, *A Gust of Plumes: A Biography of Lord Twining of Godalming and Tanganyika*, 1972, p.78

¹¹¹ ‘William Kauntze’, R Trail (ed.), *Munk’s Roll*, 1968, pp.222–3; p.223

¹¹² ‘Roland Dowdeswell’, *BMJ*, ii, 1956, p.305; ‘William Ansorge’, *Who Was Who, 1897–1916*, Vol. I, 1966 [1920], p.19

¹¹³ ‘Arthur Milne’, *Who Was Who, 1929–1940*, Vol. III, 1967 [1941], p. 945

¹¹⁴ WD Foster, ‘Robert Moffat and the Beginnings of the Government Medical Service in Uganda’, *MH*, 13, 1969, pp.237–50, p.237; ‘Mary Turton’, *BMJ*, ii, 1958, p.1048; ‘John Carothers’, *BMJ*, 300, 1990, p.1010; Jock McCulloch, ‘The Theory and Practice of European Psychiatry in Colonial Africa’, in D Bhugra and R Littlewood, (eds.), *Colonialism and Psychiatry*, New Delhi, 2001, pp.76–104, p.92

¹¹⁵ ‘John Buchanan’, *Who Was Who, 1971–1980*, Vol. VII, 1981, p.108

¹¹⁶ RHL/MSS.Afr.s.1872/84 Hutton, ‘Memorandum on Service’

¹¹⁷ C Wilcocks, *A Tropical Doctor in Africa and London*, unpublished autobiography [Wellcome Library], Surrey, 1977, p.41

¹¹⁸ RHL/MSS.Afr.s.1872/33 Cole, ‘Memorandum on Experiences’

¹¹⁹ RHL/MSS.Afr.s.1872/9 RE Barrett, ‘Memorandum on Experiences in the Colonial Medical Service in East Africa, 1928–55’, 18/03/1983

then Director of the IMS, while still at medical school in Belfast. He changed his focus from India to Africa, however, after meeting Peter Clearkin who told him about his life in the Colonial Medical Service in Tanzania.¹²⁰ John Gilks remembered that the appointment in 1912 of his colleague, Arthur Williams, had resulted from their discussions in London sometime before.¹²¹

Despite the strong push to distance Colonial Service recruitment from its early associations with patronage, informal networks of professional influence continued to operate — often in an uncontrived way between friends and family members — throughout the period. These interactions grew in importance as serving officers encouraged their younger colleagues, and sometimes their family members, to do the same. These networks were a crucial factor in creating a sense of group belonging and unity among Colonial Medical Service members (Chapter 5).

3.4 The Religious Factor

Reading through the reminiscences and obituaries of ex-Colonial MOs, the numerous references to Christianity are striking.¹²² Firm and explicit Christian beliefs were intrinsic to popular middle and upper-middle class religious expectations typical of the period. A desire to continue a Christian tradition confirmed and extended a historically-based convention that related many of the ideals of masculinity, including those needed for an African adventure, with Christian principles.¹²³ It is reasonable, therefore, to link some individuals' decisions to join the Colonial Medical Service to the religious connections specifically forged between medicine and the tropics through the work of medical missionaries. Missionaries had for a long time shouldered the burden of responsibility for medical care in the continent. Some medical graduates found Africa attractive precisely because it provided an

¹²⁰ It was directly on this recommendation that Calwell applied (he was later to work, in 1930, in Clearkin's Dar Es Salaam laboratory) RHL/MSS.Afr.s.1872/24 HG Calwell, 'Memorandum on Experiences in the Colonial Medical Service in Tanganyika, 1930–49', 25/04/1983, pp.1–2

¹²¹ 'Arthur Williams', *BMJ*, i, 1958, p.1421

¹²² Many obituaries speak of firm Christian belief as one of the main guiding lights of MOs. ODRP researchers have also noted this common denominator of Christianity. Holden, *Doctors and Other Medical Personnel*, p.1

¹²³ N Vance, *'The Sinews of the Spirit': The Ideal of Christian Manliness in Victorian Literature and Religious Thought*, Cambridge, 1985

opportunity to combine their professional preferences with these enduring images of Christian good works. In the context of Empire, a Christian identity further demarcated European communities from the uncivilised 'other' and was one of the key markers, especially in the early period, of civilised, rational and moral life of the white ruling communities. In choosing to become Colonial Medical Service doctors, rather than missionaries, some young graduates were engaging with these influential images of the Christian in Africa while pragmatically choosing a higher paying, more sociable and less religiously rigorous alternative to the missionary life.

* * *

Much of the fashionable literature that would have been read by potential candidates associated Empire with Christian values.¹²⁴ Many popular books and magazines portrayed the imperial adventure in Christian terms. Although by the end of the Edwardian period much of the unconcealed Christianity in these texts became increasingly overtaken by a more jingoistic rhetoric, many of the core Christian values remained.¹²⁵ The popular Boy Scout movement too, although never overtly Christian (indeed, keen to distance itself from being too much so), had a tone that was "certainly moralistic" and typical of the nineteenth-century ideals that linked good moral fibre with imperial adventure.¹²⁶

Many MOs were the children of clerics¹²⁷ or missionaries.¹²⁸ It was a tradition moreover, that some officers were self-consciously proud of. Dawson Milne, who wrote a short history of the East African Medical Service was keen to stress the Christian legacy. He presented the Colonial MOs he worked with in a direct line of

¹²⁴ Eg, works by Marryat, Ballantyne and Kingston in the Victorian era, Henty and Stables in the late nineteenth century and Johns (creator of 'Biggles') in the inter-war years. This tradition continued right up until the mid 1950s see P White, *Jungle Doctor and the Whirlwind*, 1952. For more on imperial literature see 'Introduction' in J Richards (ed.), *Imperialism and Juvenile Literature*, Manchester, 1989, pp.1-11

¹²⁵ JM MacKenzie, *Propaganda and Empire: the Manipulation of British Public Opinion, 1880-1960*, Manchester, 1997 [1986], pp.199-226

¹²⁶ A Warren, 'Popular Manliness: Baden-Powell, Scouting, and the Development of Manly Character', in JA Mangan and J Walvin (eds.), *Manliness and Morality: Middle-Class Masculinity in Britain and America, 1800-1940*, Manchester, 1987, pp.199-219, p.202

¹²⁷ Eg, George Allen, Farnworth Anderson, Robert Archibald, Arthur Bagshawe, Arthur Claypon-Gray, James Hunter, Archibald Mackinnon, Norman MacLennan, Dawson Milne and Mary Turton

¹²⁸ Eg, William Ansorge, Arthur Morley, William Kauntze and Robert Moffat

succession from David Livingstone himself. The first government PMO, Robert Moffat, was, he reminded his medical department colleagues, the grandson of Livingstone's father-in-law and it was felt proper that MOs would be aware and proud of this tradition stemming from its brave medical missionary beginnings.¹²⁹ Moffat himself was said to have chosen a government career over a private one precisely because it gave him the opportunity "to do good work as a missionary".¹³⁰

Personal recollections provide a revealing insight into doctors' motivations. One of the earliest medical men to join the Colonial Medical Service in Uganda in 1895, William Ansorge, did so after being rejected by the Church Missionary Society.¹³¹ Arthur Williams remembered how his image of Africa had been specifically influenced through its strong connections with the missionary movements and the Christian literature of his youth that had stressed associations between religion and Africa. His faith was so strong that he even considered giving up medicine at Cambridge for a career in the church, but persevered and eventually became a candidate for the Universities Mission to Central Africa (UMCA). The Colonial Service seemed like a good alternative only when he discovered that missionary life with the UMCA would not allow him to marry.¹³² William Kauntze similarly chose medicine only as "an after-thought in that it would prepare him for missionary work"; the tropical medicine certificate course additionally activating his interest.¹³³ During his time as a Colonial MO he continued his active religious involvement and enjoyed many years as a churchwarden to All Saint's Cathedral, Nairobi.¹³⁴

Hugh Trowell, whose religious faith was so strong that he was ordained an Anglican minister after he retired from the Colonial Medical Service, succinctly summed up the missionary/adventurer associations that coloured his pre-application image of Africa. He described his decision to be a doctor in Africa as having been

¹²⁹ AD Milne, 'The Rise of the Colonial Medical Service', *KEAMJ*, 5, 1928-9, pp.50-8, p.50

¹³⁰ Foster, 'Robert Moffat and the Beginnings of Government Medical Service', p.241

¹³¹ WD Foster, *The Early History of Scientific Medicine in Uganda*, Nairobi, 1970, p.15

¹³² RHL/MSS.Afr.s.1872/153a Williams, 'Detailed Memoranda', p.1

¹³³ 'William Kauntze', Trail (ed.), *Munk's Roll*, p.223

¹³⁴ 'William Kauntze', *EAMJ*, 24, 1947, p.425

driven by a “mixture of idealism, a background of Christian belief, and a desire for adventure”.¹³⁵ His involvement with the Student Christian Movement while studying medicine had first seriously aroused his interest in a colonial career, as it highlighted the Colonial Service as a means of tying his medical education in with his humanitarian beliefs without becoming a missionary — The group was “not quite certain how much they wanted to convert people”; rather they wanted to help create an infrastructure in Africa (“[T]he people needed schools, they needed hospitals, they needed roads, they needed administration”).¹³⁶ Trowell was not alone in adopting a religious career after resigning from the Colonial Medical Service. A small, but significant minority took a similar path demonstrating how close the link could be between governmental medical works and missionary ideals.¹³⁷

There was mutual suspicion between missionaries and government officials, particularly after 1914, but the boundaries between the two groups were not as rigid as has sometimes been argued.¹³⁸ The Colonial Medical Service temporarily employed some missionaries with relevant experience during times of particular personnel shortages. Thus Charles Edwards, who had been a missionary in Kenya since the mid 1890s, served, according to the *Colonial Office List* of 1911, for a year as a temporary MO. Also Robert Stones, who had worked for the Church Missionary Society in Africa since 1911, spent a year on secondment to the Colonial Medical Service (Tanzania).¹³⁹

Associated with this Christian motivation was the less explicitly religious humanitarian motive in taking up a Colonial medical career. This subtle change in emphasis was particularly evident after World War One, when the direction of

¹³⁵ RHL/MSS.Afr.s.1872/144a HC Trowell, ‘Detailed Memorandum on Service as a Medical Officer, Lecturer in Medicine and Specialist Physician in Kenya and Uganda, 1929–57’, [n.d. c.1984], p.2

¹³⁶ RHL/MSS.Afr.s.1872/144b Trowell, tape 1B

¹³⁷ Eg. On retirement Clare Wiggins joined the Church Missionary Society and then was ordained an Anglican minister; Marcus Broadbent left the Colonial Medical Service to join the Church Missionary Society in Uganda; Hugh Trowell was also ordained upon retirement and acted as a hospital chaplain; Arthur Brown became a ship’s surgeon and then a missionary; Frederick Wright, described as having been “always a missionary at heart”, became a missionary in Tanzania. (‘Frederick Wright’, *BMJ*, 313, 1996, p.556); Douglas Snell became a churchwarden on retirement.

¹³⁸ Beck, *History of British Medical Administration*, pp.53–7

¹³⁹ Robert Stones had a wide-ranging missionary career in Nigeria, Egypt, Tanzania and Uganda. See ‘Robert Stones’, *BMJ*, ii, 1961, pp.966–7

colonial rhetoric turned to caring for African communities, rather than just the Europeans stationed there. Humanitarian issues began to feature in the promotional literature as a motivation for joining the Service: "In few other branches of human activity can the work so surely be its own reward".¹⁴⁰ Doctors became increasingly self-conscious about the part played in the improvement of public health conditions and health education for those in less fortunate positions than themselves. Some members of the Colonial Medical Service were motivated to work in Africa by work they had already undertaken in underprivileged areas of Britain. Raymond Barrett remembered that part of the career's attraction (aside from the enthusiastic press it had received from his boss) was the humanitarian side to the work. "My experience of general practice in a rather insalubrious neighbourhood certainly influenced my decision", he recalled.¹⁴¹

Not everyone who became a government doctor in Africa did so solely to help those less fortunate than themselves, but these were still notable factors in influencing career selection. Associations between Africa and Christian missions were long established in the public mentality and it is striking how many MOs recalled some religious connection in making their choice. Furse himself was quite aware that the Colonial Service offered a new secular opportunity to take on some jobs that had formerly been associated principally with religion. The career provided a suitable choice for "the idealist who wanted to serve his fellow men, the sort of man who, for example, would probably have gone into the Church 50 or 60 years ago".¹⁴² As will be discussed in the following section, the fashionable allure of Empire manifested itself in many other ways, but the association between Africa and good Christian works was an important part of the complicated tapestry of cultural appeal that held sway over people's choices.

¹⁴⁰ Jeffries, *Colonial Empire*, p.154

¹⁴¹ RHL/MSS.Afr.s.1872/9 Barrett, 'Memorandum on Experiences', p.1

¹⁴² PRO/CO/877/16/15 'Meeting of the Public School's Career's Association'

3.5 The Adventure Factor

Public enthusiasm for Empire was at its peak in this period. In opting for an Empire career young doctors were taking part in something that held very distinct connotations of national pride, adventure and exoticism. Furthermore, while most people in Britain only experienced Empire at a distance, whether through the books and magazines they read, the music hall songs they knew, the imperial exhibitions they attended, the statues and memorials in public parks and (later) the cinema films they watched, active involvement immediately conferred extra status, perhaps even a degree of valour, upon actual participants.¹⁴³ This section briefly traces some of the most ubiquitous motifs and their roots in popular conceptions of Empire. It then analyses the evidence that doctors quite self-consciously entered into the colonial career because it seemed to present adventure, excitement and difference.

* * *

The appeal of an African adventure had deep roots in the literary-romantic Empire building enthusiasm illustrated by the immense popularity of travel writers and adventurers such as David Livingstone (1813-1873), Richard Burton (1821-90), John Hanning Speke (1827-64) and Mary Kingsley (1862-1900).¹⁴⁴ Livingstone in particular forged links between adventure, medicine and religiosity — his monograph, *Missionary Travels* sold 70,000 copies in the first few months after its publication in 1857.¹⁴⁵ As Driver has argued, this fashion both caused and extended enduring popular representations of the explorer and traveller and “helped to produce an image of Africa as a field for European endeavour, and the myths which surround them — above all the image of Livingstone as a humanitarian pioneer — provided a potent means of justifying subsequent imperial adventures”.¹⁴⁶ These early

¹⁴³ MacKenzie, *Propaganda and Empire*

¹⁴⁴ Furthermore, these authors built on a late-eighteenth century tradition of African travel writing, eg, J Bruce, *Travels to Discover the Source of the Nile*, 1790 and M Park, *Travel in the Interior Districts of Africa*, 1799.

¹⁴⁵ P Brantlinger, ‘Victorians and Africans: The Genealogy of the Myth of the Dark Continent’, *Critical Inquiry*, 1985, 12, pp.166–203, p.176

¹⁴⁶ F Driver, *Geography Militant: Cultures of Exploration and Empire*, Oxford, 2001, p.82. Although as Driver has pointed out, the image of Africa that was publicly presented was often fraught with tensions. See F Driver *Geography, Empire and Visualisation: Making Representations*, 1994

associations, which Driver pinpoints as having peaked in 1890 with the publication of Henry Morton Stanley's *In Darkest Africa*, were subsequently extended further and altered through the new enthusiasm for British Empire, especially after World War One when Britain's presence in Africa solidified.¹⁴⁷ Many novels produced as part of this tradition are still popular today such as Joseph Conrad's, *Heart of Darkness* (1899); JH Paterson's, *The Man Eaters of Tsavo*, (1907); Somerset Maugham's, *The Explorer* (1908); Karen Blixen's, *Out of Africa* (1937), indicating how deeply these ideas permeated society.¹⁴⁸

Much work has been done on the type of rhetoric used to describe the colonial experience in fictional and non-fictional mediums.¹⁴⁹ But Empire touched people in many ways beyond the written word; it was promoted through schools, pageants, exhibitions, biscuit tins and Liberty's department store.¹⁵⁰ Clearly young men applying for work abroad were attracted to Empire careers as part of this wider tradition. Images of a strange land full of exotic creatures and people had great appeal, and Africa in particular (precisely because of its early adventure associations) became a place onto which people could project their fantasies. The game was bigger, the skies wider and the people were more different.

Magazines such as the hugely popular *Boys Own Paper*, *The Magnet* or *Gem* promoted the imperial life of adventure.¹⁵¹ These publications, and others, reinforced prevalent ideas of masculinity and heroism; only the strong and intrepid, it was

¹⁴⁷ Driver, *Geography Militant*, p.82 Also worth noting is the influence of early societies and institutions in disseminating information about Africa before the 1890s. DO Helly, 'Informed Opinion' on Tropical Africa in Great Britain, 1860-1890', *AA*, 68, 1969, pp.195-217

¹⁴⁸ Kirk-Greene created a bibliography of novels which featured, or were by, Colonial Service entrants and has thereby shown the immense influence these novels had in both forming and perpetuating an image of a desirable and adventurous career (although none of the novels he includes detail a specifically Colonial Medical Service career). A Kirk-Greene, 'The Colonial Service in the Novel' in John Smith (ed.), *Administering Empire: The British Colonial Service in Retrospect*, 1999, pp.19-48

¹⁴⁹ D Hammond and A Jablow, *The Africa That Never Was: Four Centuries of British Writing About Africa*, New York, 1970; ML Pratt, *Imperial Eyes: Travel Writing and Transculturation*, 1992; D Spurr, *The Rhetoric of Empire: Colonial Discourse in Journalism, Travel Writing and Imperial Administration*, Durham, NC, 1993

¹⁵⁰ TG August, *The Selling of Empire, British and French Imperialist Propaganda, 1890-1940*, Westport, CT, 1985; T Richards, 'Selling Darkest Africa' in *The Commodity Culture of Victorian England: Advertising and Spectacle, 1851-1914*, Stanford, 1990, pp.119-67; JM MacKenzie (ed.), *Imperialism and Popular Culture*, Manchester, 1993 [1986]; MacKenzie, *Propaganda and Empire*

¹⁵¹ A McKay, *Tibet and the British Raj: The Frontier Cadre, 1904-1947*, Surrey, 1997, p.191

thought, could survive in such a difficult and alien place. What Stanley described as the prerequisites of “pure manliness” rather than “vain fancies” represented solid, enduring, character credentials that changed remarkably little between the 1880s and 1939.¹⁵² They were, moreover, exactly what the CO was looking for.

When a local boy got a Colonial Service job it was treated as the beginning of an adventure.¹⁵³ This was not necessarily empty rhetoric. Many of the claims made for Africa were true; it was unfamiliar, it was unhealthy and especially, before the advent of air travel, a journey to the tropics was long, expensive and arduous.¹⁵⁴ A voyage to Africa required special precautions and measures. Preparatory rituals included going to the tropical outfitters—Waugh’s *Scoop* offers an entertaining parody of the sort of paraphernalia that was deemed necessary for an African journey¹⁵⁵ — or the buying of special equipment. One needs only to look at the advertisements in a 1930s edition of the Royal Geographical Society’s *Hints to Travellers* to get a sense of the excitement over the sort of equipment required by the attentive traveller: shock-proof tropical resistant watches; water-tight packing trunks, camouflage gear, etc.¹⁵⁶

Some of these popular associations actually served to damage the reputation of the Colonial Medical Service, particularly as career destination for serious researchers or specialists. The medical school staffs’ reaction to Hugh Trowell’s career choice in 1929 aptly illustrates the reverse side of the positive images of adventure :

Of course, even East Africa had a bad name among the doctors. When it came out in [St.] Thomas’s [Hospital] that I was going, I was even given a bit of a lecture, by my immediate superior, the honorary physician. You couldn’t do any good work, any good medical work,

¹⁵² Driver, *Geography Militant*, p.126 quoting HM Stanley, *The Congo and the Founding of its Free State*, 2 Vols., London, 1885, Vol. 2, p.266, 230

¹⁵³ When Kirk-Greene was accepted as a colonial administrator in Nigeria in 1949, the local paper, the *Tunbridge Wells Courier*, ran the story ‘Sanders of the River Job for Local Boy’. Kirk-Greene, ‘The Colonial Service in the Novel’, p.19

¹⁵⁴ In 1906 a passage to East Africa took approximately two and a half weeks and it was a rough and difficult journey. It was also relatively expensive: a first class single trip from London to Mombassa in the same year cost £45. Field, ‘*Verb. Sap.*’, p.17.

¹⁵⁵ E Waugh, *Scoop*, Harmondsworth, 2000 [1938], pp.44–5

¹⁵⁶ EA Reeves, *Hints to Travellers*, Vol. 1, 1935, (11th Ed.), pp.1–2; see also description in P Mitchell, ‘Forty Years Back’ in A Kirk-Greene, *Glimpses of Empire: A Corona Anthology*, 2001, pp.278–80, p.279; for a suggested list of what a colonial wife should take see E Bradley, *Dearest Priscilla: Letters to the Wife of a Colonial Civil Servant*, 1950, pp.238–9

out there. You probably would take to whisky too much, and black women even more. I said I was getting married, so he shut up about that. But the feeling was very much against going abroad in any Colonial Medical Service. They were said to attract—not exactly the scum, but the people who wanted adventure, some shooting, big game. You would probably remain a bachelor most of the time. Then he said it was such a waste. I'd done reasonably well at Thomas's.¹⁵⁷

In general, however, Colonial Service promoters and the MOs used the rhetoric of adventure advantageously and for their own ends. Concern over health in Africa immediately offered to doctors increased standing in colonial communities (see Section 3.2). Professional opportunities for doctors in Africa opened up by the rise of tropical medicine presented a fresh field in which to shine, with the added romance of brave, selfless individuals having to endure the hardships of an unhealthy and uncivilised place. Doctors could fashion themselves relatively quickly as experts in Africa, in a way that would have needed a lifelong research career or a high-ranking hospital consultancy to achieve at home. The market for health manual and travel advice books was enormous.¹⁵⁸

Furthermore, pursuing a war on parasites and pathogens projected an heroic image for the folks back home; a parallel to the ever-present big-game hunting images of Africa played out at a microscopic medical level. Andrew Balfour himself, in a speech encouraging colonial medical recruitment, explicitly used a very similar analogy; the tropical world offered, he told his audience, “a happy hunting ground for both the sportsman and the tropical pathologist”.¹⁵⁹ The new field of tropical medicine was presented most dramatically by stressing the most grotesquely diseases, such as elephantiasis, or by making repeated reference to the gulf between African and European health practices. Stepan has drawn attention to the pictorial images of African disease contained in the most influential tropical medical textbook of the time, Patrick Manson's *Tropical Diseases: a Manual of Disease in Warm Climates*

¹⁵⁷ RHL/MSS.Afr.s.1872/144b Trowell, tape 1B

¹⁵⁸ Eg: TH Parke, *Guide to Health in Africa*, 1893; Field, ‘Verb. Sap.’ (which was endorsed by Patrick Manson in the introduction); H Ziemann, *Hints to Europeans in Tropical Stations Without a Doctor and to Travellers in Warm Climates*, [trans. P Falcke], 1910; CJ Ryan, *Health Preservation in West Africa*, 1914; *Hints on the Preservation of Health in Tropical Africa*, 1943 [1938]

¹⁵⁹ Balfour, ‘Vistas and Visions’, p.361; for a literary expression of this combination of game and parasite hunter see A Torrance, *Tracking Down the Enemies of Man*, New York, 1928

(1898).¹⁶⁰ The choice of images and the medium through which they were portrayed were, she argues, ones that emphasized exotic difference and danger. Parasite-carrying insects such as tsetse flies and mosquitoes were presented in looming close up — making them threatening and frightening — and photographs of these insects and diseases were chosen to attain maximum visual impact on European readers.¹⁶¹ There was, of course, a medical reality behind this rhetoric. Despite and because of the reputation tropical (particularly West) Africa had as a ‘white man’s grave’, it offered a particularly attention-grabbing environment in which European healthcare workers could practise.¹⁶²

The successful Colonial MO needed to be of “infinite resource and sagacity”.¹⁶³ But as Alex McKay has pointed out, it was the lure of the different “with all that symbolised” that government service candidates wanted: “[t]hey did not seek the familiar”.¹⁶⁴ In fact, group similarities and common denominators were positively stressed (above discord and divergence which certainly also existed) to demarcate the boundaries between the home country and the colony, and the colonisers and the colonised (see Chapter 5). The colonial career offered scope and opportunities that were accepted — even positively welcomed — because the work and opportunities provided were “often on a far more challenging scale than in Britain”.¹⁶⁵ The CO realised how potent these images of difference were and used them frequently in their promotional language: students at St Thomas’s were told as late as 1939 that the career would especially appeal to the medical graduate “who desires to break away from the traditional practice of medicine in this country”.¹⁶⁶ Furse reminisced similarly on the Colonial Service’s need for adventurous types:

¹⁶⁰ This went through numerous editions and a version is still in print today.

¹⁶¹ N Leys Stepan, *Picturing Tropical Nature*, 2001, pp.149–179. Also A Grimshaw, *The Ethnographer’s Eye: Ways of Seeing in Anthropology*, Cambridge, 2001.

¹⁶² Curtin, ‘The White Man’s Grave’; Curtin has analysed the statistics for West Africa and put civilian mortality somewhere between five and seven times higher than the expected death rate at home. Curtin, ‘The End of ‘White Man’s Grave’? p.88

¹⁶³ JA Carman, *A Medical History of the Colony and Protectorate of Kenya: a Personal Memoir*, 1976, p.41

¹⁶⁴ McKay, *Tibet and the British Raj*, p.75

¹⁶⁵ Smith (ed.), *Administering Empire*, p. ix

¹⁶⁶ Smart, ‘An Impression of Life in the Colonial Medical Service’, p.123

The chief attractions of the Colonial Service to the type of man we needed were, and remain, spiritual: the challenge to adventure, the urge to prove himself in the face of hardship and risk to health, of loneliness often and not infrequently danger; the chance of dedicating himself to the service of his fellow men, and of responsibility at an early age on a scale which life at home could scarcely ever offer; the pride of belonging to a great service devoted to a mighty and beneficent task; the novelty of life in unfamiliar scenes and strange conditions.¹⁶⁷

The romantic imagery of contrast between the modern world and the tropical world was used time and time again to encourage careers in the Colonial Medical Service. Emotive language stressed the “interest and beauty of the setting in which the Colonial Medical Officer is often privileged to work”.¹⁶⁸ The student audience of Balfour’s 1924 address, was led into the lecture through highly romanticised language; they were asked to imagine taking a tour in a plane “from the capricious weather and the gloomy skies of the north into balmy regions with a bright, strong sun above, and a vivid blue sea below, and...a long coast-line, bordered by a ribbon of snowy surf”.¹⁶⁹

One of the reasons why New Zealand candidates were predicted to be relatively uninterested in pursuing a Colonial Service career was because it was felt that this adventure ideal would not have as much influence on those who already enjoyed those elements within their own home cultures. Given that many candidates interviewed for the Colonial Service said that they applied through a desire to lead “an out-door life”, the CO worried that “New Zealanders have plenty of that supplied on the spot...[with] enough unbroken country to cater for a moderately adventurous spirit”.¹⁷⁰ Oddly, an attempt to stimulate interest among Australians, did not credit the Australian landscape with presenting the same opportunities and reverted to the more conventional motifs of persuasion: “a man in these services is able to enjoy a greater variety of life than his contemporary in Australia....Taking it all round it is a grand life—hard at times, but none the worse for that—and a young

¹⁶⁷ Furse, *Aucuparius*, p.221

¹⁶⁸ Balfour, ‘Vistas and Visions’, p.355

¹⁶⁹ *Ibid.*, p.356

¹⁷⁰ PRO/CO/877/3/685 Minute: Mr Denniston (? illegible), ‘Applications from New Zealanders for Appointments in the Colonial Service’, 26/01/1926

man who is fortunate enough to enter one of these fine services has before him a life of usefulness and interest".¹⁷¹

Even when negative elements were mentioned, these seemed to revel in the potential hardships opened by the colonial career: This was part of the package and one, it was emphasised, that should be embraced. The Secretary of State, Lord Lloyd reminded a group of young Colonial Service recruits what their decision entailed in 1940:

You are not going to have a soft job. You will indeed have plenty of hard work and not too many of the comforts of life, and quite possibly no lack of danger, but I know that you would not have it otherwise....In what other task can you have so much power so early? You can at the age of twenty-five be the father of your people: you can drive the road, bridge the river, and water the desert; you can be the arm of justice and the hand of mercy to millions.¹⁷²

Part of this rhetorical trend can be equated with a desire to make what Kingsley Amis termed a "*nostalgie de la boue*" (nostalgia of the mud),¹⁷³ a desire to romanticize the unromantic. The potential to suffer in Africa conferred bravery and status on the participants and emphasized once again just how distant and different Africa was.¹⁷⁴ People did not go to have an easy option; on the contrary they went to have a different, possibly harder option. The difficulties in fact served to bind the group together with common experiences and further set them apart from those who stayed at home.

Many adventurous depictions of service in Africa were images created by the officers themselves. Often they came from their own attitudes and so should be seen as being largely self-descriptive. Even if the key-players in the medical services came from 'ordinary' middle-class backgrounds, Colonial Service held connotations allowing people, if not to transcend their background, then at least to magnify their

¹⁷¹ PRO/CO/877/13/8 'Empire Careers for Australians'

¹⁷² Lord Lloyd, Secretary of State, quoted in C Jeffries, *Partners For Progress: The Men and Women of the Colonial Service*, 1949, p.19

¹⁷³ K Amis, 'Is the travel book dead?' [*The Spectator*, 1955] in M Venter, *The Spirit of Place: An Anthology of Travel Writing*, Cape Town, 1992, pp.217-8

¹⁷⁴ Hoppe argues for heroism as part of the appeal of pursuing a career in imperial science, KA Hoppe, *Sleeping Sickness Control in British East Africa, 1900-1960*, Westport, CT, 2003, pp.30-42

role in the new social setting. Normal contexts of work and leisure became intertwined and their comparative status and respect was inflated. The adventurous associations of their new life took them out of the mundane setting of Britain. As one of the earliest MOs in East Africa admitted, there was “an indescribable fascination in African travel and adventure, which draws one again and again to the Dark Continent” despite the fact that many people had died there.¹⁷⁵ The theme is a common one; Farnworth Anderson recalled that he had become interested in East Africa through his Grandfather’s large library of travel books about the region. Further interest was stimulated through several visits, while still a house surgeon, to the Great Empire exhibition at Wembley in 1924: “Every Dominion and all of the Colonies had their own pavilion, and I often used to go and learn about them all. It certainly looked in those days as if the British Empire was a stable institution, destined to last forever”.¹⁷⁶ James Hunter had a self-confessed enthusiasm for African travel literature life reinforced when he and his fiancée saw in the late 1930s “a colour film of Uganda, *The Pearl of Africa*, at the Empire Exhibition in Glasgow”.¹⁷⁷ Arthur Williams also admitted that literature on Africa helped mould his early impressions as a young man.¹⁷⁸ Robert Hennessey romantically described how he was attracted, not only by the exotic diseases he would professionally encounter, but by the landscape in which he would find them.¹⁷⁹

Some saw the career as a stepping-stone to permanent settlement in Africa.¹⁸⁰ Others saw it as a means of extending amateur interests in anthropology, exploration, sport or natural history. Undoubtedly, the career offered tangibly exciting prospects; indeed there were few non-military positions for doctors that could offer comparable opportunities.¹⁸¹ This is far from saying that the colonial life

¹⁷⁵ W Ansorge, *Under the African Sun: A Description of Native Races in Uganda, Sporting Adventures and Other Experiences*, 1899, p.3

¹⁷⁶ RHL/MSS.Afr.s.1653, Anderson, *Reminiscences*, Book I, pp.13–14

¹⁷⁷ RHL/MSS.Afr.s.1872/82 Hunter, ‘Detailed Memorandum’, p.3

¹⁷⁸ RHL/MSS.Afr.s.1872/153a Williams, ‘Detailed Memoranda’, p.1

¹⁷⁹ RHL/MSS.Afr.s.1872/75 Hennessey, ‘Learning About Disease in Uganda’, p.1

¹⁸⁰ KNA/MOH/1/9950 J Mitchell to E Northley, Governor EAP, 04/10/1920

¹⁸¹ In the 1930s, for example, negotiations were undertaken with the Royal Air Force Central Medical Establishment for “making regular arrangements for the training of Medical Officers of the Colonial

could always pay back all the dividends of excitement it promised. Many CMOs were bored with the job at times, or found facilities basic and trying.¹⁸² Occasionally negative images even entered the realms of popular literature. George Orwell's, *Burmese Days* (1934), mocked the lot of Colonial Service policeman:

It is a poor bargain to spend thirty years, ill-paid in an alien country, and then come home with a wrecked liver and a pine-apple backside from sitting in cane chairs, to settle down as the bore of some second-rate Club.¹⁸³

Negative images, though, are much harder to find than positive ones. This is partly because those who enjoyed the career were plainly more likely to want to write about it. Also, pragmatically, exotic images of adventure could sell. Books written about the colonial experience, were expected to be enlivened with drama and local colour; this did not necessarily reflect each individual's opinions or the reality of life.¹⁸⁴

Images of adventure were potent, widespread and clearly affected colonial career choices. Even famous names, confident in their tropical reputation, saw that they had originally been drawn to the career by the elements of adventure and difference it had presented. Patrick Manson justified his decision to take up employment in China because of his "adventurous spirit".¹⁸⁵ Aldo Castellani saw his decision to volunteer for the Royal Society Sleeping Sickness Expedition in Uganda as part of a tradition, in which "every young man craved adventure".¹⁸⁶ Adventure tied together colonial communities through shared risks (Chapter 5). Of course adventure was not necessarily sufficient reason for the choice of job. Doctors' daily duties provided opportunities for field observation of tropical diseases, helped the

Service in making examinations for pilots for aviation licences".PRO/CO/877/8/18 Furse, 'Progress Report for the Appointments Department, No.2', 10/12/1931, p.15

¹⁸² Geoffrey Carpenter related how "excessive boredom" in his job led him to pursue his naturalist interests. GDH Carpenter, *A Naturalist in East Africa*, Oxford, 1925, p.7

¹⁸³ Quoted in Kirk-Greene, 'The Colonial Service in the Novel' p.42

¹⁸⁴ McKay has drawn attention to this commercial aspect of the Orientalist argument. McKay, *Tibet and the British Raj*, p.206

¹⁸⁵ PH Manson-Bahr and A Alcock, *The Life and Work of Sir Patrick Manson*, 1927, p.5, quoted in Haynes, *Imperial Medicine*, p.18

¹⁸⁶ A Castellani, *Microbes, Men and Monarchs: A Doctor's Life in Many Lands*, 1960, p.29

very poorest communities, and set them apart as practitioners who were not afraid to 'get their hands dirty' in conditions which were peculiarly both far below and far above those they could ever experience professionally in the United Kingdom.

3.6 The Professional Factor

The professional opportunities offered to doctors through a Colonial Medical Service career were exceptional. First, doctors could expect to have relative professional independence, often being in charge of large districts with very little outside interference. Second, the job appealed to doctors who hoped for variety in their professional lives. The colonial doctor, at least in the early years of his career, had to be very much an 'all rounder'. Colonial medical duties usually meant that individuals had to man clinics or hospitals, perform surgery, complete all the pre-requisite administration, and take up local opportunities to observe tropical diseases that were relatively unstudied and unfamiliar. And third, while the interest in being a generalist no doubt appealed to some,¹⁸⁷ evidence from both the CO and the colonial doctors indicates that it was specifically the idea of being a tropical medical practitioner, if not an expert, that appealed to the majority. A career in the Colonial Medical Service played upon a certain amount of idealism in the minds of young medical recruits. It combined many of the powerful external values of the time (Empire, adventure, exploration) with professional opportunities of making new and necessary discoveries (within parasitology, zoology, helminthology, entomology and bacteriology) and with personal attributes that were valued highly in the early part of the twentieth century (independence, ingenuity, innovation and initiative).

* * *

The idea that the Medical Service offered an independent professional existence was pushed hard by the CO itself. The Assistant Medical Adviser to the CO, AGH Smart, emphasised that, although there would be a support network of subsidiary medical staff to assist doctors, at the end of the day what an officer "makes of his

¹⁸⁷ After taking his medical qualifications at Cambridge and then an MD, Arthur Cole became convinced that he should look for a practical career. His MD had taught him that he was "not cut out for research work" but would prefer "clinical work involving direct dealing with patients". RHL/MSS.Afr.s.1872/33 Cole, 'Memorandum on Experiences'

Hospital and District will largely depend on himself".¹⁸⁸ Charles Jefferies made a virtue out of the 'hands-on' nature of the career; Colonial MOs, he stressed, would

...deal not so much with paper problems as with men and women; he will be entrusted with responsibility, and will be able, according to his position in the Service, to reach decisions for himself, to take practical action on his decisions, and to see the results of his work.¹⁸⁹

This emphasis on an individual doctor's motivation as defining the boundaries and focus of their jobs was linked closely to notions of leadership, independence, resourcefulness and sound mind that the CO interviewers looked for (Chapter 2). Ideas of job self-definition also fitted in with the meritocratic values of the Colonial Service. Although all officers started at the bottom of the career ladder as generalists, they could subsequently specialise, especially after the 1930s when doctors were encouraged to take further specialist or postgraduate qualifications while on leave.¹⁹⁰ The CO was very keen to publicize the "almost unlimited scope for work and investigation" afforded by the colonial medical career. Because life was "[l]ived more in the open a man has every chance to exercise personality, to show administrative flair and to indicate any special professional bias or aptitude he may possess".¹⁹¹

As can be seen from some of the subsequent careers of MOs, there was a thin line between an amateur interest in natural history and a professional interest in medical zoology, particularly medical entomology. Many budding medical entomologists inclined towards work in East Africa because of the wide-ranging problems associated with sleeping sickness and malaria in the region. The Colonial Medical Service career could combine an outdoor life and interest in natural history with practical medical knowledge gained at medical school; the abundance of wildlife in East Africa presented ample opportunities learn more about the natural world. For example the obituarist of Fairfax Bell wrote "[h]is great interest in natural history was probably a deciding factor in leading him to work in the Colonial

¹⁸⁸ Smart, 'An Impression of Life in the Colonial Medical Service', p.124

¹⁸⁹ Jeffries, *Colonial Empire*, p.126

¹⁹⁰ *Colonial Service Recruitment*, No.3, 1935, p.16

¹⁹¹ Smart, 'An Impression of Life in the Colonial Medical Service', p.123

Service”.¹⁹² Similarly, Geoffrey Hale Carpenter, who “exemplified a peculiar British product, the doctor naturalist who allowed what was at first a hobby to become the pivot of his career”, was influenced in his initial career choice through the abundance of opportunities for expanding his amateur interests in natural history in a more professional capacity.¹⁹³ After hearing a lecture on insect-borne diseases as a young student, he “decided forthwith that the field was for him”.¹⁹⁴

Other keen naturalists included Arthur Bagshawe,¹⁹⁵ Enrico Bayon,¹⁹⁶ William Lamborn (who spent most of his working life in Nyasaland, although serving in Tanzania),¹⁹⁷ and Aubrey Hodges.¹⁹⁸ Some officers, of course, took natural historical interests in distinctly non-medical directions. Rather than study parasites or disease vectors, they concentrated on birdlife and big game. Foster’s blunt historical assessment of William Ansorge, as one whose “contribution to medicine in Uganda was nil”¹⁹⁹ is supported by Ansorge’s own description of his experiences in East Africa. His book makes no reference to medicine at all, but concentrates on describing his explorations from the east to the west coast and the subsequent categorisation of his zoological findings.²⁰⁰ For others, interests in the broader zoological aspects of natural history developed later in their lives, as a direct consequence of living in Africa. Ralph Brockman, John Shircore and Clare Wiggins were all remembered as great enthusiasts for natural historical pursuits.²⁰¹

¹⁹² ‘Fairfax Bell’, *BMJ*, i, 1972, p.450

¹⁹³ Also see the comments in this obituary that relate his love of natural history to his choice of career in Africa. ‘GDH Carpenter’, *Lancet*, i, 1953, pp.300–1, p.300; Perhaps Carpenter was the most serious of all the East African naturalists of the period. On retirement from the Colonial Service he became Professor of Zoology at Oxford (1933–48), served as Vice-President of the Linnean Society, (1935–6); and President of the Royal Entomological Society (1945–6), he also published many books and papers on the subject. ‘GDH Carpenter’, *BMJ*, i, 1953, pp.406–7

¹⁹⁴ *Ibid.*, p.406; also ‘Obituary’, *The Times*, 31/01/1953, p.8

¹⁹⁵ ‘Arthur Bagshawe’, *Lancet*, i, 1950, pp.693–4

¹⁹⁶ ‘Enrico Bayon’, *BMJ*, ii, 1952, pp.1260–1, p.1261

¹⁹⁷ ‘William Lamborn’, *BMJ*, ii, 1959, pp.310–1, p. 311

¹⁹⁸ ‘Aubrey Hodges’, *BMJ*, i, 1946, p.933

¹⁹⁹ Foster, *Early History of Scientific Medicine*, p.15

²⁰⁰ Ansorge, *Under the African Sun*, 1899

²⁰¹ Brockman spent the early part of his career in Somaliland where he authored *Mammals of Somaliland* [n.d.] and *British Somaliland* [n.d.] See ‘Ralph Brockman’, *Who Was Who, 1951–1960*, Vol. V, 1967 [1961], p.318; ‘John Shircore’, *Lancet*, ii, 1953, p.94; ‘Clare Wiggins’, *BMJ*, i, 1966, pp.363–4, p.364

Closely associated with these proclivities for natural history was the self-conscious decision to be part of the relatively new specialism, tropical medicine. A career in Africa opened up new avenues for medical investigation. By 1931 Furse could analyse this appeal to doctors in the second of his progress reports for the Appointments Department.

Experience has shown that Medical Officers enter the Service for two main reasons: (1) the attraction of work in backward countries as compared with that of a general practitioner or of an officer in one of the Fighting Services; (2) the desire to take up some special branch of medicine and surgery.

Financial considerations prevent the average young practitioner, who has gained his experience by means of resident or other appointments on the staff of Institutions, from specialising on his own account. It is known that the Colonial Service offers unique opportunities for practice in general medicine and surgery and that every encouragement is given to an Officer to pursue any specialist work in which he may be interested.²⁰²

In the early years of the twentieth century with the growth of bacteriology and parasitology, a new medical optimism concerning the tropical world developed. Even though mortality statistics were still higher for those serving in the tropics than at home, they were no longer so drastic that a career in Africa meant an unacceptably high chance of premature death. Doctors were an essential component of schemes to 'manage' Africa through health work.²⁰³ The Colonies presented a new professional medical field with "opportunity for pioneer work in virgin or only partially explored fields",²⁰⁴ providing opportunities for "pioneer work in an undeveloped country and in the mode of living which is that best adapted to conditions of work and environment".²⁰⁵

Furthermore, although medical facilities were meagre, this was offset by the abundance of resources (specimens, cases), for doctors to establish, and perhaps later also expand, their position in the tropical medical field. A career *in situ* gave doctors

²⁰² PRO/CO/877/8/18 Furse, 'Progress Report for the Appointments Department, No.2', pp.9-10

²⁰³ Curtin, 'The End of 'White Man's Grave'?

²⁰⁴ PRO/CO/877/16/15 'Meeting of the Public School's Career's Association'

²⁰⁵ Smart, 'An Impression of Life in the Colonial Medical Service', p.123

greater authority to speak of the effects of particular diseases through first-hand observations, and to have a practical sense of the environment and the daily problems of African life. The African job's associations with tropical medicine — one of the most fashionable new medical specialisms — therefore offered a situation whereby a medical man could have a realistic chance of making a name for himself.²⁰⁶

Significantly, many of the most important tropical medical discoveries had been made by doctors resident in the colonies, rather than by research scientists in the home country; for example, Manson in China, Castellani in Uganda, Ross in India. By the first decade of the twentieth century these successes must have held some sway on ambitious young men's choices. A humorous poem appearing in *Punch* in 1903, gives a feel for the very early enthusiasm and rush for tropical medical knowledge:

Men of Science, you that dare,
Beard the microbe in his lair,
Tracking through the jungly thickness
Afric's germ of Sleeping Sickness,
Hear, oh hear my Parting plea,
Send a microbe home to me!²⁰⁷

A tropical medical career created an opportunity to add prestige to a fledgling administration (and to the nation back home) by playing an active part in the field. These issues were afforded even more national importance because of the cutting edge status of tropical medicine among professional medical researchers during the period.

The way doctors defined themselves in terms of this research science culture is briefly addressed in Chapter 5; what is important here is that the Service actively promoted these opportunities as a reason to join. When Furse described the reason why Canadian medical graduates should feel especially drawn to the career, one of the reasons he offered was that it afforded "rich opportunities for research in fields otherwise inaccessible to them".²⁰⁸ Interestingly, the well-publicised lack of facilities

²⁰⁶ The fashion of tropical medical careers to further Empire has been argued particularly by J Farley, *Bilharzia: A History of Imperial Tropical Medicine*, Cambridge, 2003 [1991]; Hoppe, *Sleeping Sickness Control*

²⁰⁷ 'Lines by an Insomniac', *Punch*, 16th September 1903, p.185, quoted in M Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire 1900–1940*, Cambridge 2002 [1992], p.66

²⁰⁸ PRO/CO/877/2/49403 Furse, 'Notes for Proposed Question and Answer in the House of Lords as to the Scheme for the Admission of Canadians to the Colonial Service', 04/06/1923

in Africa were presented less of a hindrance than a challenge. As Andrew Balfour pointed out, Laveran, Manson and Bruce all worked in peripheral locations without modern laboratory facilities. The portable microscope rather than the laboratory was the most powerful tool of the tropical specialism: “it and its appurtenances constitute a laboratory in themselves”.²⁰⁹

The official tone was confirmed by the officers themselves. Many Colonial MOs listed “good therapeutic prospects” offered by tropical medicine as one of the chief attractions of the job.²¹⁰ To Robert Hennessey, a talk from a WAMS Officer, led him to decide, “there seemed to be good opportunities in a variety of fields”.²¹¹ Although he had expressed a preference for a posting in West Africa or Malaya, he was offered Uganda, which he concluded would be suitable, not least because “[t]ropical [d]iseases were in ample supply”.²¹² The new tropical field of scientific endeavour with so many causes and effects to be uncovered and documented created far more chances (and adventurous challenges) for medical men to make a mark on the field.²¹³ By being transported far from the perceived mundanities of urban life, the ‘right sort of man’, enjoyed research opportunities, which although hindered by lack of facilities and rough conditions, were not only more numerous, but more urgent and pressing than the old-world diseases back home in England. To add further glory, they were intertwined with the successful establishment of Empire and, as the period progressed, with broader welfare policies concerned with the health and wellbeing of millions of indigenous peoples.

These professional attractions clearly influenced the decisions of doctors deciding upon their future careers. The Colonial Medical Service offered a job that was relatively independent and unrestricted, while simultaneously having an infrastructure that encouraged people to gain extra qualifications and specialise should they so desire. The career paradoxically had professional appeal to both

²⁰⁹ Balfour continued... “‘Cherish your microscope’ would be a good motto for every man and woman entering the portals of the profession” Balfour, ‘Vistas and Visions’, pp.369-70

²¹⁰ RHL/MSS.Afr.s.1872/82 Hunter, ‘Detailed Memorandum’, p.3

²¹¹ RHL/MSS.Afr.s.1872/75 Hennessey, ‘Learning About Disease in Uganda’, p.3

²¹² *Ibid.*, pp.3–4

²¹³ This aspect is stressed in Balfour, ‘Vistas and Visions’, pp.353–74

decided and undecided graduates. On one hand the chance to do a 'bit of everything' could have been attractive to young graduates who were not yet sure which branch of medicine they wanted to pursue. On the other hand, the Service had definite attractions for the more focused student especially for those specifically interested in tropical medicine.²¹⁴

3.7 Other Reasons

This chapter so far has surveyed the main factors that influenced doctors career choices; of course there were exceptions to this pattern. Most doctors would have applied because of a combination of attractions, and equally some may have applied for reasons not touched upon at all. This second point is particularly relevant to doctors who found themselves in colonial medical careers after other professional experiences had taken them to Africa. Some doctors joined the Colonial Medical Service after a period in the army, frequently having had their appetite whetted through a period of service in the RAMC in Africa. Similarly, some joined governmental service after being commissioned to go to East Africa on separately organised scientific reconnaissance exercises, particularly those sent to Uganda under the auspices of the Royal Society. Another group that deserves mention were those who went to Africa as private practitioners and only subsequently sidestepped into a Colonial Service career.

* * *

During the Great War, recruitment to the Colonial Medical Service fell, young medical men were required to join the war effort and those that did not were needed to administer to the health of people at home.²¹⁵ Awareness of the colonial career grew during this period, however, and for some the attraction was awakened by the international experience afforded through the circumstances of the war. Several Colonial MOs joined the Service directly, or very soon after serving with the

²¹⁴ A dual appeal also recognised by the CO itself "An officer in the Colonial Medical Service thus has unique opportunities for the practise of his profession in general medicine and surgery as well as in the special branch of tropical diseases" *Colonial Service Recruitment*, No.3, 1935, p.10

²¹⁵ As discussed in Chapter 2, after 1914, if a man had not undergone war service he was ineligible to join the Colonial Service

RAMC, often after a period of military service in East Africa. James Armstrong was first taken to East Africa through his service with the RAMC,²¹⁶ as were Robert Cormack,²¹⁷ Frederick Corson,²¹⁸ and Edward Langton.²¹⁹

Some MOs had participated in earlier wars and had forged their links to the Continent then: Sidney Hinde, having fought in both the Arab Campaign (1892–94) and the M'Baruk Campaign (1895–96) moved into civil medical duties for several years;²²⁰ Francis Auden, John Davey and 20 other Colonial MOs identified, originally came to Africa as military doctors during the Boer war.²²¹

Some officers were seconded to East Africa from the WAMS to help make up shortfalls of staff and to help with particular health emergencies.²²² The most common type of appointments and secondments, however, with regard to East Africa were undoubtedly the Royal Society Sleeping Sickness Commissions originally set up to investigate the sleeping sickness epidemic in Uganda in 1902, but continued until after the First World War. These commissions, partly because of their government backing, worked closely with the Colonial Service and the military and often negotiated the temporary enrolment of their employees in the Colonial Medical Service. Some of the doctors evidently enjoyed the work so much that they stayed on long after their association with the Royal Society had expired. Many of these temporary drafts were military secondments, for example Robert Archibald, Herbert Bateman, Alexander Fraser, Arthur Gray, Dudley Skelton and Forbes Tulloch. Gerald Keane, head of the medical service in Uganda between 1928–33, began his Colonial Service career through a Royal Society initiative that originally brought him to Uganda as a venereal disease expert from the army. Others, like

²¹⁶ 'James Armstrong', *EAMJ*, 13, 1936–7, pp.58–9

²¹⁷ 'Robert Cormack', *EAMJ*, 31, 1954, p.186

²¹⁸ 'Frederick Corson', *EAMJ*, 25, 1948, pp.18–9, p.18

²¹⁹ 'Edward Clarence', *EAMJ*, 14, 1937–8, pp.138–9, p.138

²²⁰ 'Sidney Hinde', *Who Was Who, 1929–1940*, pp.643–4

²²¹ Results obtained from prosopography, see also 'John Bernard Davey', *BMJ*, 3, 1967, p.743

²²² John O'Connell, Henry Hamilton and George Keigwin were all secondments from WAMS

Muriel Robertson and Herbert Duke took part in the Royal Society's work in an entirely civilian capacity.²²³

A few doctors went to East Africa to seek their fortunes in a private medical capacity. This route of entry was most relevant for Kenya, with its large settler community and consequent opportunities for private practice.²²⁴ For example the Bödekers arrived in Kenya in 1896, worked privately for a few years, and then joined the Colonial Service in 1899.²²⁵ Farnworth Anderson originally went to Kenya to be an assistant in a private practice to Gerald Anderson (no relation), but shortly afterwards approached the DMS to join the Colonial Service, having decided that prospects for promotion in private practice in Kenya were few and that general practice was, anyway, "not in his line".²²⁶ Both Charles Tichborne²²⁷ and William Heard²²⁸ seemed to have come out to Kenya originally to work privately for Walter Macdonald (who unusually walked the other way and had left government service to become a private practitioner).²²⁹

Occasionally, doctors started Colonial Service careers in unusual circumstances, but early career exposure to Africa was the most common stimulus to finding other permanent work there.²³⁰ For these doctors the Colonial Medical

²²³ 'Herbert Duke', *Who Was Who*, 1961–1970, p.323

²²⁴ After World War One the Soldiers' Land Settlement Scheme encouraged retired doctor soldiers to set up medical farms in Kenya. The land grant of a farm (becoming entirely the resident's property after ten years) must have been a great incentive to many seeking their fortunes. Participation in this scheme was less encouraged for government doctors, however. KNA/MOH/1/9889 A Milne to W Field, 29/09/1919; KNA/MOH/1/9950 'Private Secretary, Kenya to J Mitchell, 18/11/1920

²²⁵ 'Henry Albert Bödeker', *EAMJ*, 17, 1940–1, pp.171–2, p.171

²²⁶ Unusually, Anderson seems to have got the job locally, without having to have returned to London for interview RHL/MSS.Afr.s.1653 Anderson, *Reminiscences*, Book 1, p.20

²²⁷ Tichborne's early history is related in KNA/MOH/1/5513 'Confidential Memorandum on Private Practice by Government Medical Officers in the East Africa Protectorate', 18/06/1909

²²⁸ Although Heard does not appear in the *Colonial Lists*, the *Medical Directory* in 1911 listed him as working in a practice entitled 'MacDonald and Heard'. By 1918 his entries in the *Medical Directory* list him as being a Captain in the EAMS, so it is likely that he joined the service in a temporary capacity to help the war effort.

²²⁹ KNA/MOH/1/5513 W Radford to PMO, 09/07/1909

²³⁰ For example Henry Gordon who came to the Colonial Service aged 65 in a consultancy capacity at the end of his career. 'Henry Laing Gordon', *EAMJ*, 24, 1947, pp.313–4; p.314; Henry Bödeker "Eurasian by birth, small in stature and his skin was almost black", 'escaped' to Kenya because he thought he would be more accepted there than in Glasgow where he had qualified. Trzebinski, *Kenya Pioneers*, p. 9

Service offered an opportunity to continue working in a place they enjoyed, and in which they had already made social, and often emotional, connections.

* * *

Relatively few doctors specified their reasons for joining the Colonial Medical Service, and even if the sample were doubled, interpretive problems would still exist. Although general themes can be identified directly and others pieced together through evidence presented by other historical studies, personal circumstances are invariably characterised by internal contradictions and a lack of definition. People rarely relate to their own lives in compartmentalised categories. Robert Hennessey's memoir best captures the problems of capturing this type of history:

It would be pleasant to be able to say that my arrival in the African medical field was the result of careful planning, to achieve a long-cherished ambition. Nothing could be further from the truth. There was no fixed star in my firmament; practical considerations led to deviations; my interests were apt to vary; and fortuitous happenings had unexpected effects.²³¹

Yet, although no 'perfect' or ultimate explanations emerge, there are enough similarities to allow insight into some common motives and rationales. Doctors as a collective group were, after all, subject to similar professional influences and market pressures; the young recruits all existed communally in a time that held established conceptions of acceptable cultural values and expectations, and the CO's terms and conditions of Service offered a tangible check list against which officers could individually assess job prospects. Although priorities changed throughout the period and were liable to dissimilar interpretations by different individuals, a valid general assessment is possible.

Many of the reasons for joining the Colonial Service were closely connected to the selection criteria used by the Service (Chapter 2). The motives of doctors and CO recruitment policies were inextricably intertwined. For example, the CO quite naturally preferred candidates who were enthusiastic about the ideal of Empire. As the period progressed the Colonial career became more popular. This gradual

²³¹ RHL/MSS.Afr.s.1872/75 Hennessey, 'Learning About Disease in Uganda', p.1

upward trend was not always reflected numerically in recruitment figures, which in turn were subject to separate economic and social factors. By 1931, however, the *BMJ* felt able to describe the Colonial Medical Service as ranking “among the premier Services of the Empire”²³² and by the end of Word War Two, the Colonial Service, from the European perspective at least, was seen generally as a “respected and sought after Crown career”.²³³ Furthermore, it had increased its sense of common identity, one that still is evident among retired colonial officers today.²³⁴ Although this sense of group belonging clearly grew out of shared practical experiences and common institutional purposes, it can also be related back to the circumstances in which doctors first chose the career above other options available to them. The expectations held in the home country shaped their professional perspectives to an important degree once they had begun medical work in East Africa. This was a chain of events that would colour what MOs deemed to be acceptable and unacceptable in their jobs, how they perceived themselves both individually and as a cadre and, later, even their memories.²³⁵

²³² ‘The Colonial Medical Services’, *BMJ*, ii, 1931, p.21

²³³ A Kirk-Greene, *On Crown Service: A History of HM Colonial and Overseas Civil Services, 1837–1997*, 1999, p.8

²³⁴ The Overseas Pensioners Association still produces a bi-annual journal for former Colonial Servants. The Corona Club, the official Colonial Service club, closed as recently as 1999.

²³⁵ In a long neglected study (recently revisited by sociologists of science), Frederick Bartlett argued that people used frameworks of knowledge about the world based on prior experience to interpret and remember events (sometimes in a way that tended to build in errors and, at times, outright fabrications). While I am not suggesting that MOs ‘made up’ experiences, it is still instructive to be aware of this tendency to reinterpret one’s past. F Bartlett, *Remembering: A Study in Experimental and Social Psychology*, Cambridge, 1932. My thanks to Professor Bloor for pointing out this interesting interpretative model to me.

4. Colonial Medical Experiences

You have no idea how primitive Africa is. You'll never do any good medical work. You'll take to whisky and black women.... Damn it man, it's such a waste of your talent.... All you will do in East Africa is shoot game, have a bit of an adventure.¹

Whereas the preceding two chapters dealt with the bureaucratic processes and issues raised in *becoming* a Colonial MO, this chapter and the next examines some of the experiences of *being* a MO once appointed to British East Africa. Although several academic works have considered the medical history of the region, there has not been much systematic description of the organisation of colonial medical administration or the collective experiences of government doctors in the field.² Most general Colonial Service histories have concentrated on policies rather than people.³ There has been little assessment of distinctively Medical Service experiences and nothing about them in the East African context.⁴

In an attempt to amend this omission, this chapter reconstructs some of the key elements of the colonial medical encounter. As no single official job description existed for the various ranks within the Medical Service, and no single organisational model provided an immutable template for all methods of colonial medical administration, this argument has been pieced together from a large evidential base.⁵ The resulting picture, therefore, describes the general situation at the expense of exploring the subtleties of individual experiences, which naturally differed depending on time, place and personality.

¹ WL/CMAC/PP/HCT/A5 E Bray, *Hugh Trowell: Pioneer Nutritionist*, unpublished biography, 1988, [Chapter 2] p.18

² Perhaps the most striking example is Beck's monograph. Despite its title and considerable use as a history of medical policy in the region, this book offers virtually no description of the daily lives of the medical personnel and the structure of the administration. A Beck, *A History of the British Medical Administration of East Africa: 1900–1950*, Cambridge, MA, 1999 [1970]

³ J Smith (ed.), *Administering Empire: The British Colonial Service in Retrospect*, 1999; EE Sabben-Clare, DJ Bradley and K Kirkwood (eds.), *Health in Tropical Africa During the Colonial Period*, Oxford, 1980

⁴ This is a comment on the secondary sources and does not include memoirs by doctors.

⁵ This lack of a specific job description has also been noted by Kuklick. H Kuklick, *The Imperial Bureaucrat: The Colonial Administrative Service in the Gold Coast, 1920–1939*, Stanford, CA, 1979, pp.5–6; see also A Kirk-Greene, 'Bureaucratic Cadres in a Traditional Milieu' in JS Coleman (ed.), *Education and Political Development*, Princeton, 1965, pp. 372–407, p.378

The first section (4.1) describes the organisation of the Colonial Medical Service. Unsurprisingly, the discrete identities of the three colonies meant that each had their own particular focus or medical interest that encouraged certain types of medical organisation over others. Uganda was characterised by a strong missionary presence and had a relatively rapidly emerging schedule to educate Africans as healthcare workers; Kenya had a powerful and vocal white settler community with which to contend; and Tanzania a very different set of concerns resulting from its former German rule and a relatively small British settler population (see Chapter 1). Although individual medical policies were affected by these differences, the general personnel organisation of the Colonial Medical Service followed the same basic pattern in all three places. In some ways the similarities are natural enough as the CO in Britain governed them all. This section outlines departmental structures and the main job titles as well as broadly describing the official duties assigned to them. It describes the MOs' practice rather than the policies they followed, although there was some overlap in these two areas.

The second section (4.2) outlines the common denominators within the practical organisation of medical care and its administration in the three countries. The way healthcare was physically and demographically distributed is described, particularly highlighting the use of the dispensary system and medical safaris as a means of extending western medicine to the rural areas. The changing focus of medicine is traced, especially the growing status afforded to public health issues after 1919. This growing interest extended official duties in practical terms as well as broadening theoretical expectations of the rôle colonial medical departments were expected to fulfil.

Section three (4.3) examines evidence providing a more personal understanding of being a MO. First, the typical methods of induction into the Service are briefly described. The overriding characteristics of the job likely to have been experienced by most employees are summarized. Naturally enough the job contained both attractive and less attractive features; on one hand it offered officers a large degree of independence and the ability to develop a broad skill base; on the other hand, many MOs found things difficult owing to the rudimentary conditions and lack of facilities. For some it was extremely pressured and even personally

dangerous at times. The examination of the less attractive features of the job presents evidence of complaints over the problems inherent in the colonial medical career. Many MOs were vocal in their discontent with general and local features of their professional lives. Special mention is made of the arguments presented to the CO by the BMA on behalf of Colonial doctors over the terms and conditions of employment. Examination of frustrations and criticisms helps to complete the picture of how medical colonial life was perceived by those who participated within it.

The final section (4.4) concentrates on women doctors of the cohort. In many ways the experiences of this small group were identical to those of their male contemporaries, but some important differences make them worthy of consideration in their own right. Some medically qualified women came to East Africa as colonial wives. Although never formally recognised on the colonial payroll, they played a vital support rôle in the provision of routine medical services.

Although there were clearly local differences, the structure of the Colonial Service created many similarities. In terms of bureaucratic organisation, the departments followed the structural model typical of medical departments throughout the British Empire. This administrative structure was heavily based on the organisation of the WAMS (unified in 1902), which itself had been modelled on an earlier administrative prototypes used in the organisation of the IMS.⁶ In the early formative years, the medical departments of Kenya and Uganda were established on equivalent bureaucratic principles before they merged between 1903–8.⁷ When British administration was established in Tanzania it also modelled itself on the Kenyan and Ugandan precedent.⁸ Regional proximity and shared British rule meant that, especially after improved transport systems were completed, Medical Department heads would meet together and confer over policies and priorities,

⁶ 'Organisation of the Colonial Medical Service', *BMJ*, i, 1902, pp.347–8

⁷ These similarities were acknowledged at the time. KNA/MOH/1/5517 untitled document [History of British Medical Administration in East Africa], [n.d. c.1909]

⁸ KNA/MOH/1/7973 J Davey, PMO Tanzania to A Milne, PMO Nairobi, 13/04/1921

working towards coordination wherever practicable.⁹ Building on these common roots, this chapter emphasises similarities above differences, to give an impression of the common colonial medical experience and to offer a synthesis of what, practically speaking, being a Colonial MO in East Africa entailed for most officers.

4.1 Organisation of the Colonial Medical Service

Described in the simplest terms, the medical bureaucracies were run in a conservative and hierarchical manner.¹⁰ Officers were expected to work themselves into a position of pre-eminence and, until they had done so, to obey their superiors and to afford fellow officers respect fitting their rank.¹¹ This typical ‘white-collar’ method of bureaucratic organisation was similar to the quasi-militaristic ethos traditionally promoted at British public schools and was favoured within most public service cultures by at the time.¹² Four core grades of officer made up the colonial medical personnel during most of this period: the head of department, the deputy head, the senior officials and the rank and file MOs.¹³ Supporting this contingent of medically qualified British staff, were European laboratory assistants, clerical assistants and nursing staff. There also existed a large network of non-European subsidiary staff, made up principally of Indians and (by the end of the period) Africans who worked as hospital assistants, compounders, sub-assistant surgeons, dispensers and laboratory assistants.¹⁴

⁹ Eg, PRO/CO/533/231 PMOs’ Conference, 1920; See also Beck, *History of British Medical Administration*, pp.183–5

¹⁰ “[A] kind of pyramid” to quote C Jeffries, *Partners for Progress: The Men and Women of the Colonial Service*, 1949, p.96

¹¹ PRO/CO/850/12/11 ‘Seniority’, *Colonial Regulations: Being the Regulations for His Majesty’s Colonial Service*, 1932, pp.95–96

¹² This seems even more fitting when it is remembered that most of the early medical departments were military administrations before they became civil ones. Early debates in the *BMJ* also called for the organisation of the Colonial Medical Service to be based upon the model provided by the Army Medical Services. G Evatt, ‘Notes on the Organisation of the Colonial Medical Service of the Empire’, *BMJ*, ii, 1896, pp.863–4; CH Eyles, ‘The Colonial Medical Service: a Rejoinder’, *BMJ*, i, 1897, p.216

¹³ Job titles often changed. Throughout this chapter, I use the *earliest* job titles when referring in a general, non-specific, context to a job. In the majority of instances the earliest given job title was the one that was in place for the largest proportion of the period.

¹⁴ Eventually Africans in the European medical establishment in East Africa could obtain full medical degrees. J Iliffe, *East African Doctors: a History of the Modern Profession*, Cambridge, 1999

Two points illustrate the bureaucratic philosophy of the Service and define the professional culture of which all officers were a part. First, the higher up an officer was in the Colonial Medical Service the less clinical and more administrative their job became. Indeed, some officers commented that they would prefer to be passed over for promotion than take on the onerous paperwork expected of the senior ranks.¹⁵ Second, the Service prided itself on its meritocratic culture; all officers essentially received the same on-the-job training and rose up the ranks over time. The higher positions were filled through promotion of those who had “rendered good service”,¹⁶ although occasionally they were staffed via transfers from the medical departments of other British territories or (rarely) through the establishment of special senior consultant positions.¹⁷ This provided a very structured career path for Service entrants, although in smaller territories with few senior positions the possibility of promotion was dispiritingly remote. To this end, one of the main aims of the Service unifications of the 1930s was to make inter-territorial transfers easier and so enhance options for promotion for more ambitious candidates.¹⁸

As the medical departments grew job titles correspondingly became more varied, reflecting increasing bureaucracy and specialization. During the early years there were only two possible positions within the Medical Departments of Kenya and Uganda: those of PMO and MO.¹⁹ By 1939 there were twelve different medical positions within the Kenya Medical Department, eleven in Tanzania and ten in

¹⁵ HG Calwell, ‘Nineteen Years in the Colonial Medical Service’, *UMJ*, 65 (supplement), 1993, pp.(s)1–(s)42, p.(s)35 Although this comment refers to a change in job offered to Calwell in the mid 1940s it would be safe to assume that he derived these views earlier on in his career. Clifford Braimbridge too was said to have shied away from a chance of the Medical Directorship of Kenya because he feared that it would involve him too much in administrative duties and isolate him from, his first love, surgery. JA Carman, *A Medical History of the Colony and Protectorate of Kenya: a Personal Memoir*, 1976, p.67

¹⁶ *Miscellaneous No.99: Colonial Medical Appointments*, 1921 [29th Ed.], p.3; *Colonial Service Recruitment No. 3A: The Colonial Service. Information for the use of Candidates for Appointment to the Colonial Medical Service*, 1931, p.5

¹⁷ Such as that created in 1931 for Henry Gordon, as consultant psychiatrist to Mathari Hospital, Kenya.

¹⁸ Jeffries, *Partners For Progress*, pp.41–2; Not that MOs were necessarily happy with the prospects of unification, especially the thought of being transferred, see ‘The Colonial Medical Services: Statement by the BMA’, *BMJ, Supplement*, 1926, pp.9–10

¹⁹ It was not until 1903 that job titles aside from these two were officially listed for the Uganda Medical Department (the following year for Kenya) PRO/CO/613/2 Uganda Bl.Bk, 1902–3; PRO/CO/543/3 EAP Bl.Bk., 1903–4

Uganda.²⁰ The new job titles, while remaining structured around the four 'core' positions, reflected the creation of specialised posts and a desire to establish a broader spread of senior positions. The aim was to make the administration less overtly 'top down' and autocratic and increase prospects for promotion. Certain new senior positions accommodated changing health priorities, for example Principal Sanitation Officer (PSO) established in Kenya in 1913,²¹ Sleeping Sickness Officer, established in Tanzania in 1926²² and Principal of Mulago Medical School, established in Uganda in 1928.²³

The period before 1920 was one of establishment and consolidation of the colonial medical administration. During this time the medical departments sought to define and regulate the duties associated with each medical rank, as well as establishing procedures and setting up physical infrastructures, such as hospitals and dispensaries. By the late 1920s as Britain's position in Eastern Africa solidified, the medical departmental organisation became more complex. Departments were divided up into distinct branches and divisions under as new regulations for the EAMS were introduced.²⁴ Later, the centralising reforms of the 1934 unification encouraged a simpler and more standardised structure.²⁵

From the time of the formal unification of the EAMS in 1921 moves were being made to encourage homogeneity. Large-scale changes in nomenclature of the job titles were instituted in 1925 and 1934 not only to reflect more up-to-date ideas of departmental orientation, but also to contribute to the desired goal of an increasingly

²⁰ *The Dominions Office and CO List*, 1940, pp.366-7; p.491; p.509 NB: The *CO List* published information from the previous year; information derived from this source is presumed to have occurred during the year *before* the publication date.

²¹ JL Gilks, 'The Medical Department and the Health Organization in Kenya, 1909-1933', *EAMJ*, 9, 1932-3, pp.340-54, p.345

²² *The Dominions Office and CO List*, 1927, p.453

²³ This replaced the title 'Medical Superintendent, Mulago' on the establishment of Mulago Medical School. *Ibid.*, 1929, p.478

²⁴ For a concise explanation of all of the administrative changes introduced in the 1920s which favoured division of the Medical Departments of East Africa into specialist branches see Kenya, *An.Med.Rep.*, 1926, Nairobi, 1927, p.3

²⁵ For an announcement and explanation of these changes see Kenya, *An.Med.Rep.*, 1933, Nairobi, 1935, pp.2-3

standardised service.²⁶ It was only in 1925 that the first formal guidelines were published briefly describing, the structure of the Medical Departments and the duties attached to each main position.²⁷

* * *

The Four Core Positions

Headship of the Medical Department (PMO, DMSS, DMS)

The head of the Medical Department was directly answerable to the Governor. The post changed very little in its remit throughout the period, although by 1939 the head was responsible for a larger body of medical personnel servicing a much wider section of the population. Initially in all three dependencies as the head was called Principal Medical Officer (PMO). In 1925 Kenya and Uganda changed the title to Director of Medical and Sanitary Services (DMSS) and in Tanzania it was changed to Director of Medical Services (DMS).²⁸ At unification of the medical services in 1934 the title DMS was adopted in all three territories.²⁹

The departmental headship was the highest-paid medical position in the dependency. The post carried ultimate responsibility for the “administration and control of all Government medical and sanitary establishments and the distribution of their personnel”.³⁰ It was an exclusively organisational and management position, although a PMO might go out of his way to keep a hand in with the more practical

²⁶ PRO/CO/612/11 ‘Changes in Medical Titles’, *UP Gov. Gaz.*, 15/08/1925, p.256; [These changes were formalised in] PRO/CO/612/11 ‘The Public Officers (Change of Titles) Ordinance’, 1926’, *UP Gov. Gaz.*, 15/01/1926, p.16; see also PRO/CO/542/20 ‘Medical Officers (Change of Titles) Ordinance’, *KC Gov. Gaz.*, 24/02/1926, p.281; PRO/CO/542/32 ‘Bill to Provide for the Change of Title of Certain Public Officers, 1934’, *Kenya Gov. Gaz.*, 30/01/1934, p.104; See also PRO/CO/850/12/13 Circular Despatch: T Stanton to Colonial Governors, 11/1932—this document expresses the hope that members of medical departments in all colonies will comply with new standardised titles. The first published schedule is *Miscellaneous No.441: The Colonial Medical Service, Special Regulations by the Secretary of State for the Colonies*, 1934

²⁷ *African (East) No.1103: Regulations for the East African Medical Service*, 1925, pp.5–6

²⁸ *The Dominions Office and CO List*, 1926, p.254, p.442, p.459

²⁹ *Ibid.*, 1935, p.342, p.485. In theory at least the job title had changed in all territories, but in fact, it did not appear as changed for Tanzania until the following year’s *CO List*. Also PRO/CO/542/32 ‘Bill to Provide for the Change of Title of Certain Public Officers, 1934’

³⁰ *African (East) No.1103*, p.5

aspects of medicine.³¹ Despite the fact that the head of the Medical Department rarely, if ever, needed to practice medicine as part of his professional commitments, he was always a qualified doctor, usually one who had started off as MO and worked his way up through the Service.³² The PMO customarily had a seat on the colonial government's executive and legislative councils and was closely involved in the overall governance and legislature of the colony, particularly issues related to public health legislation.³³ The PMO was also a prominent member of many urban administrative boards, especially those with medical interests.³⁴

Additional to this political rôle, the PMO was accountable for the overall management of the Colonial Medical Service and the general regulation of medicine within the territory, such as the registration of private, commercial and governmental medical practitioners),³⁵ the issuing of licences to Indian Sub-Assistant surgeons,³⁶ and the allocation of medical expenditure and revenues. In the earlier period, the PMO, often worked closely with the Public Works Department in organising new buildings and facilities for medical provision.³⁷ The PMO sanctioned all local Colonial Service appointments and assumed responsibility for all MOs once they had arrived in the colony. As the head of all personnel, the PMO granted leave, stipulated the posting and duties of doctors, enforced discipline. He arbitrated in professional disputes and investigated any complaints brought by non-governmental parties over the provision or quality of official medicine within the territory.³⁸ The PMO was responsible for the submission of departmental reports requested by

³¹ For example, Burke Gaffney wrote of Shircore "[E]ven when he was director, he used to slip into the laboratory". 'John Owen Shircore', *Lancet*, ii, 1953, p.94

³² C Jeffries, *The Colonial Empire and its Civil Service*, Cambridge, 1938, p.154

³³ It is worth noting that it took some years for legislative councils to be set up in each colonial dependency— i.e. Kenya in 1905; Uganda in 1920 and Tanzania in 1926. In 1938 the DMS ceased to be a member of the Executive Council, Kenya. Colony and Protectorate of Kenya, *An.Med.Rep.*, 1938–9, (*Abbreviated*) [n.d. c.1940], p.1

³⁴ G Maclean, 'Medical Administration in the Tropics', *BMJ*, i, 1950, pp.756–61, p.757

³⁵ This responsibility was exercised via the PMO's Presidency of the Medical Registration Board. *Ibid.*

³⁶ Carman, *Medical History of Kenya*, p.9

³⁷ KNA/MOH/1/1497 'Medical Building Requirements', PMO to Director Public Works Department, 14/09/1906; 'Uganda Building Requirements, 1907-08', J Will, PMO Uganda, to Superintendent Public Works Department, 21/09/1906; KNA/MOH/1/1633 'New Buildings Needed', Memorandum: A Milne to Director Public Works Department, 29/06/1912

³⁸ KNA/MOH/1/504 A Milne, PMO Kenya, to C Ainsworth, 16/03/1913

central government in London; he had to submit the medical figures and estimates via the annual Blue Books as well as prepare the Annual Medical and Sanitary Report covering all aspects of medical administration within the colony. Theoretically (although it was often impracticable), the PMO was expected to undertake with his deputy periodic tours of their area to gain a “proper appreciation of the medical problems of the country”.³⁹

Deputy Headship of the Medical Department (DPMO, DDMSS, DDMS, DDSS, DDLS)

It was in 1902 (in Uganda) that first mention was made of the existence of a deputy position.⁴⁰ From that time onwards, with the exception of a short period in Kenya (1909–1913 when the position was temporarily abolished), at least one deputy, but sometimes several, acted as second-in-command to the head of each Medical Department.⁴¹ The position underwent many changes in both its nomenclature and designated responsibilities; changes that were directly reflective of the way the Medical Department was structured at various times.⁴² From the mid 1920s to the mid 1930s, the favoured method of organising the medical departments in the East African territories was to separate them into medical, sanitary and laboratory branches (see Section 4.2). A director headed each branch with a title usually indicating their particular area of responsibility: Deputy Director of Medical Services (DDMS); Deputy Director of Sanitary Services (DDSS) and Deputy Director of

³⁹ Gilks, ‘Proposed Expansion of the Medical Services in Kenya’, *KMJ*, 2, 1925–6, pp.318–20, p.319

⁴⁰ It was titled Assistant Medical Officer, paid at a higher rate to other MOs. PRO/CO/613/1 UP Bl.Bk., 1901–2

⁴¹ Gilks, ‘The Medical Department and the Health Organization’, pp.342–3; See also, East Africa Protectorate, *An.Med.Rep.*, 1913, 1914, p.12

⁴² The history of the deputyships is very complicated. Initially there was just one deputy position in each territory, the job title being DPMO. Other high-ranking positions, such as the Director of Laboratories (DL) and Chief Sanitary Officer (CSO) were regarded as separate appointments. In 1925, two deputies with the same job title (DDMSS) were created in Kenya and three in Uganda. The Ugandan posts were differentiated in terms of their responsibilities: one was in charge of native services, one medical and one sanitary. In Tanzania, two separate directors headed the medical and sanitary branches by 1926. The Director of Laboratories was not officially made a deputy directorship in Tanzania until 1927. By 1929 the anomalies were largely ironed out. Each territory basically had three deputy directorships representing the three main branches of medicine. Although there were some changes and differences, broadly this state of affairs remained until unification in 1934.

Laboratory Services (DDLs).⁴³ After unification in 1934 this system was abolished and gradually it became normal for a to single deputyship with the title Deputy Director of Medical Services (DDMS) to exist within each territory's medical hierarchy.⁴⁴ To compensate for lost posts, an assistantship (Assistant Director of Medical Services, ADMS) was additionally created at an intermediary level between the rank of deputy PMO and that of SMO.⁴⁵

The DPMO directly supported the head of the Medical Department. A purely administrative position, it was the route by which the most ambitious officers could eventually rise to the directorship. The DPMO acted as the first in command during times when the PMO was away from office and assisted generally in all duties carried out by the head of department. Deputies who headed the separate branches of the colonial medical establishment, naturally had extended responsibilities. The DDMS supervised and organised the MOs as well as overseeing the running of hospitals and dispensaries; the DDSS was responsible for the organisation and duties of the sanitary support staff, often working in close association with the Public Works Department in the building of new hospitals and the hygienic planning of cities and public buildings; the DDLs was responsible for the management of the bacteriologists, pathologists, laboratory assistants, chemical analysts and microscopists. In accordance with this division of labour, it was expected that deputies would compile the section of the annual medical and sanitary report relevant to their realm of responsibility.

⁴³ The title Deputy Director of Laboratory Services (DDLs) was never used in Uganda. Laboratory medicine was officially supervised by the DL or, after 1930, the Director of the Human Trypanosomiasis Institute. These positions seemed to be on the same level as the other Deputy Directorships and were basically equivalent to the DDLs used in Tanzania and Kenya.

⁴⁴ In 1933 Kenya lost the position of DDLs, and Uganda amalgamated two of its three separate deputy directorships (those of the medical and sanitary services) to form a single undifferentiated job title called DDMS. (*The Dominions Office and CO List*, 1934, pp.387–8; p.462). In 1934 Kenya also abolished separate deputyships in favour of one single general position of DDMS (*Ibid*, 1935, p.342). Tanzania, however, continued until 1936 to have three separate branches headed by three different deputies (*Ibid*, 1937, p.470)

⁴⁵ For an explanation of this change occurring after unification in 1934 see Kenya, *An.Med.Rep.*, 1933, Nairobi, 1935, p.3

Senior Medical Officer (SMO)

The first SMO in British East Africa was appointed in Uganda in February 1904. The holder, Robert Moffat, had stepped down from his position as head of the Medical Departments of Kenya and Uganda because he felt that the joint directorship was not only excessively “unwieldy” but also that its focus on administrative matters had distanced him too greatly from his original professional interests.⁴⁶

The number of SMOs in office at any one time varied. In the period before 1920, they usually made up around 5% of the entire medically-qualified workforce and in the later period, they constituted between 10% and 14% of the medical department.⁴⁷ Unlike the higher positions, the grade of SMO remained a constant feature of all three medical departments from its institution to the end of the period and beyond. SMOs’ responsibilities were mostly divided regionally. They managed several medical districts, undertaking a combination of administrative and clinical duties. While they carried a heavy burden of administrative responsibility, supervising a large geographical area, SMOs were also expected to offer practical assistance on difficult clinical cases and to participate in, as well as manage, local medical initiatives. The SMO had to prepare regional medical reports and report back to the head of department on any particularly interesting provincial developments as well as making suggestions for improvements.⁴⁸ They were also required to undertake regular supervisory tours checking out and reporting on all aspects of district medical work. Depending on the geographical area of responsibility, an SMO was often in charge of a particular hospital or medical programme; if there was no SMO the nearest MO often carried out these duties.

⁴⁶ WD Foster, ‘Robert Moffat and the Beginnings of the Government Medical Service in Uganda’, *MH*, 13, 1969, pp.237–50, pp.247–8. Foster incorrectly claims that Moffat stood down from his position as PMO to that of an “ordinary Medical Officer”; Government records contradict this and the 1906 *CO List* shows Moffat as SMO.

⁴⁷ In 1910 3 of 58 medical departmental workers were SMOs; in 1920, 11 of 87; in 1930, 27 of 193 and in 1939, 15 of 147

⁴⁸ See suggestions regarding Nairobi and Mombassa KNA/MOH/1/629 J Haran, SMO to PMO, 20/03/1912

Medical Officer (MO, DMO, MOH, HO)

Most colonial medical workers were MOs, sometimes known in rural postings as District Medical Officers (DMOs). These doctors constituted the main colonial medical infrastructure and undertook the bulk of the medical work in the colonial Empire. Most appointments involved taking charge of a (sometimes extensive) medical district within which officers usually attended to the local hospital, oversaw sanitation and provided basic medical and surgical care to the community. Unlike their equivalents in Britain, the MOs' job required considerable management skills. Not only did the government doctor have to care for a large number of patients, they also had to supervise and train the Indian and, later, African support staff who were responsible for much of the day-to-day medical work in the regions.⁴⁹

Supplementary duties of a MO included medico-legal work such as acting as police surgeon,⁵⁰ undertaking the duties of expert witness and attending executions.⁵¹ They were also expected to conduct post mortems, issue death certificates, and examine and report on the health of government officials about to proceed on leave (or those who had been invalided).⁵² Additionally, they could be called upon to examine locally appointed candidates for government service.⁵³ Particularly in the period before World War One, local government doctors often had to set up (sometimes from scratch) their own facilities in the areas to which they were posted. This became less frequent as the medical infrastructure became more established, but

⁴⁹ *African (East)* No.1103, p.7. The rôle of the Indian Sub Assistant Surgeons was very large: "They carried the burden of all routine administrative duties in the hospital, did their share of clinical work and in the absence of the DMO on tour, took over the care of all officials, expatriate and indigenous, and a good deal of the bazaar population". RHL/MSS.Afr.s.1872/9 RE Barrett, 'Memorandum on Experiences in the Colonial Medical Service in East Africa, 1928-55', 1983, p.4

⁵⁰ Carman, *Medical History of Kenya*, p.72

⁵¹ RHL/MSS.Afr.s.1872/153a AW Williams, 'Detailed Memoranda on Experiences in the Colonial Medical Service in Uganda and Tanganyika, 1931-1949', [n.d. c.1983], p.9

⁵² From 1919 in Kenya, MOs were also asked to recommend exactly how long leave for European officials (they had examined) should be. KNA/MOH/1/9410 Circular Despatch: PMO, Kenya to all MOs, 23/08/1919

⁵³ *African (East)* No.1103, pp.7-8

plenty of early evidence points to doctors' close involvement with house building, hospital planning, local staff training and the setting up of rural dispensaries.⁵⁴

The character of a MO's job predictably varied depending upon whether they were located in an urban or rural posting; over time it also became further extended and formalised through different types of colonial legislation. In municipal postings MOs were sometimes expected to participate in many of the local government structures, for example the town planning boards, the central boards of health and the boards of medical registration.⁵⁵ The legal remit of an MO's duties was defined by laws passed to regulate infectious diseases and public health and by disease-specific legislation with regard to sleeping sickness, plague, malaria, venereal disease etc. The earliest public health responsibilities of MOs were set out in very specific and localised regulations (such as the 1899 East Africa Plague Regulations), and gradually this type of legislation became the model through which the policing and custodial rôle of the MO became extended and further enunciated.⁵⁶ The first general Public Health Ordinance was only passed in East Africa in 1913 (in Kenya).⁵⁷ Many of the rôles defined for MOs in this and later Public Health Ordinances — the issuing of health passes, the right to impose restrictions on the movements of natives, the

⁵⁴ Eg, David Donald had to work closely with the Public Works Department in planning and establishing a district hospital in Eldama Ravine, Kenya. RHL/MSS.Afr.s.ff.312–321, D Donald, Sketch Plan of New Hospital, c.1900; see also Hodges involvement with hospital building in Uganda RHL/MSS.Afr.s.1782, ADP Hodges, Diaries 1898–1907, 04/04/1899

⁵⁵ The legislation establishing various city boards is extensive and cannot all be listed. Some prominent examples include: KNA/MOH/1/8 [Drugs and Poisons Ordinance, 1909] Board Membership letters, Nairobi, Kenya 1911–12; PRO/CO/542/4 'Medical Practitioners and Dentists Ordinance, 1910', *EAP Gov. Gaz.*, 01/10/1910, p.575; PRO/CO/612/3 'Medical Registration Ordinance, 1913', *UP Gov. Gaz.*, 31/05/1913, pp.221–5; PRO/CO/542/16; PRO/CO/737/1 'Medical Practitioners and Dentists Proclamation, 1920', *TT Gov. Gaz.*, 22/07/1920, pp.143–5; PRO/CO/737/1 'Drugs and Poisons Proclamation, 1920', *TT Gov. Gaz.*, 02/09/1920, pp.175–9; 'Central Board of Health (Procedure Ordinance, 1922', *KC Gov. Gaz.*, 04/01/1922, p.31

⁵⁶ Via these regulations MOs could "medically examine any and every person on board any ship arriving at any port of the Protectorate" PRO/CO/457/1 'East Africa Plague Regulations, 1899', *EA&U Gov. Gaz.*, 01/06/1900, pp.1–4, p.3

⁵⁷ PRO/CO/542/7 'Public Health Ordinance, 1913', *EAP Gov. Gaz.*, 15/10/1913, p.875; PRO/CO/542/12 'Public Health Ordinance, 1918', *EAP Gov. Gaz. Supplement No.1*, 28/01/1918 pp.1–51; PRO/CO/542/15 'Public Health Ordinance, 1921', *Kenya Gov. Gaz.*, 21/09/1921, pp.825–65; PRO/CO/542/24 'Public Health (Amendment) Ordinance, 1928', *Kenya Gov. Gaz.*, 12/10/1928, pp.1654–5; PRO/CO/542/36 'Public Health (Amendment) Ordinance, 1938', *Kenya Gov. Gaz.*, 18/01/1938, p.47; PRO/CO/684/4 'Public Health Ordinance, 1935', *Uganda Acts*, 1931–9, pp.265–313; PRO/CO/684/4 'Public Health (Amendment) Ordinance, 1939', *Uganda Acts*, 1931–9, pp.1–6; PRO/CO/737/1 'Infectious Diseases Ordinance, 1920', *TT Gov. Gaz.*, pp.205–7; PRO/CO/737/1 'Townships Ordinance, 1920', *TT Gov. Gaz.*, pp.260–1

enforced inspection of private business and dwelling houses, the power to demand cleaning and disinfection etc. — were simply more comprehensively articulated extensions of earlier Township Ordinances.⁵⁸ Infectious Diseases Ordinances, passed in each territory and frequently amended throughout the period, provided Officers with the right to destroy or remove potentially infectious property, to prohibit the movements of possibly infected people and to order their removal to segregation camps.⁵⁹ In accordance with the later implementation of a policy to govern East Africa through indirect rule, some of these responsibilities were gradually transferred to the native authorities (see Section 4.2).⁶⁰

Public Health legislation fundamentally changed the remit of a MO's work. The legislation, which was received with "astonishment and incredulity" in many quarters, significantly "modified" the views of all MOs.⁶¹ Indeed, the public health rôle of the MO eventually became so important that it often took precedence over clinical duties. The officer who "mastered the intricacies of the new Public Health Ordinance" reminisced one MO, "became overnight a man with a future".⁶² This increased responsibility had, however, been long in the making. Although the job title of Health Officer (Later, MOH) was added to the personnel complement of Uganda and Kenya as early as 1904, the real kick-start to systematic interest in public health matters can date to the visit of sanitary expert, Professor William Simpson to Kenya, Uganda and Zanzibar on the request of the British government in 1913 (see

⁵⁸ PRO/CO/457/1 'Nairobi Municipal Bye-laws' [passed 1900], *EA&U Gov. Gaz.*, 01/01/1902, pp.6–7, p.6; PRO/CO/457/5 'Nairobi Township Rules, No.3, 1905', *EA&U Gov. Gaz.*, 15/10/1905, p.320–6; PRO/CO/612/3 'Entebbe Township Rules, 1913', *UP Gov. Gaz.*, 15/06/1913, p.247; PRO/CO/737/1 'Rules for the Township of Dar Es Salaam, 1919', *Gov. Gaz., Occupied Territory of German East Africa*, 15/10/1919, pp.50–5; PRO/CO/737/1 'Sanitary Rules, Dar Es Salaam, 1920', *TT Gov. Gaz.*, 02/08/1920, pp.151–4; PRO/CO/737/1 'Township Rules, 1923', *TT Gov. Gaz.*, 09/03/1923, pp.133–62

⁵⁹ The first Infectious Diseases Ordinances were: PRO/CO/457/3 'Uganda Infectious Diseases Ordinance, 1902', *EA&U Gov. Gaz.*, 01/11/1902, pp.357–8; PRO/CO/457/4 'Infectious Diseases Ordinance, 1903', *EA&U Gov. Gaz.*, 01/08/1903, p.266; PRO/CO/737/1 'Infectious Diseases Ordinance, 1920', *TT Gov. Gaz.*, 14/10/1920, pp.205–7

⁶⁰ This system of government was set up in Tanzania in 1925. J Iliffe, *A Modern History of Tanganyika*, Cambridge, 1994, [1979], pp.320–1; 1921 in Kenya via the Public Health Ordinance. PRO/CO/542/15 'Public Health Ordinance, 1921'; 1935 in Uganda. Uganda Protectorate, *An. Med. Rep.*, 1935, Entebbe, 1936, p.5

⁶¹ Gilks, 'The Medical Department and Health Organization', p.349

⁶² AJ Boase, 'Reminiscences of Surgery in Uganda', *EAMJ*, 31, 1954, pp.197–203, p.201

Section 4.2).⁶³ After Simpson's damning report on sanitary conditions in British East Africa, MOHs possessing a Diploma in Public Health (DPH) could be appointed on a slightly higher salary scale than regular MOs, usually to the larger urban centres or ports. In addition to their inspection and regulatory duties, Port Health Officers were responsible for enforcing quarantine regulations, inspecting in-coming vessels and issuing them with clean health certificates, where appropriate.⁶⁴

The jobs of MOs and MOHs might be officially different, but the shortage of doctors and the close relationship between public health and general medical welfare was so intimate that most officers, irrespective of their title or possession of a DPH, performed both functions daily.⁶⁵ This enforced generalism was a regular feature of the colonial medical life: just as the difference between the duties of MOs and MOHs tended to be blurred, there was little official acknowledgement of the difference between surgical and medical positions.⁶⁶ Although surgical work was assigned to officers known to prefer such tasks wherever possible, most MOs were expected to perform basic surgery. The first specifically surgical job title was not introduced until 1920, when the position of Resident Surgical Officer (RSO) in the European Hospital, Nairobi was established. In the same year the part-time position of District Surgeon (DS) was set up in Kenya. This allowed some MOs to divide their time between settler farming and surgical work, and also helped increase staffing in remote areas that did "not warrant the whole time services of a Medical Officer".⁶⁷ The position of DS endured in Kenya, but other surgical job titles in East Africa were reserved for senior officials tied to hospitals.

⁶³ PRO/CO/457/4 'Notice', *EA&U Gov. Gaz.*, 15/07/1903, p.251; for information on Simpson see RA Baker and RA Bayliss, 'William John Ritchie Simpson (1855–1931): Public Health and Tropical Medicine', *MH*, 1987, 31, pp.450–65

⁶⁴ For life as a MOH see RR Scott, 'The Growth of a Public Health Service in a Tropical Town', *EAMJ*, 10, 1933–4, pp.130–44; Calwell, 'Nineteen Years in the Colonial Medical Service', esp. pp.(s)2–3

⁶⁵ *Colonial Service Recruitment No.3: Information Regarding the Colonial Medical Service*, 1935, p.29, p.30, p.35. R Scott, (DMS, Tanzania 1935–45), expressed his conviction while still a Senior Health Officer that "public health and medicine are one and the same thing" and that the duties of an MO could not be subdivided. Scott, 'The Growth of a Public Health Service in a Tropical Town', p.132

⁶⁶ Boase, 'Reminiscences of Surgery', p.197

⁶⁷ KNA/MOH/1/9950 Private Secretary, Kenya to J Mitchell, 18/11/1920

Another rôle of the MO that expanded over time was that of the educator. As the first point of contact between the African people and the European medical services, the MO became cast more frequently as educator and public health advisor in accordance with the changing priorities of colonial administration. The pragmatic acknowledgment that MOs alone could not effectively manage the healthcare of such large populations led to a policy of placing nominal responsibility for health in the hands of the native populations themselves. Schemes were systematically introduced, from the 1920s, to educate Africans as auxiliary health workers.⁶⁸ In all three countries, the rôle of the MO went beyond formal tuition. He became increasingly used as a general mouthpiece through which matters of sanitary and epidemiological importance could be promoted. The rôle of the MO as health propagandist was increasingly enunciated, particularly under the influence of Drs Gilks and Paterson in Kenya and Owen in Tanzania.⁶⁹ As the head of the Uganda Medical Service formally pronounced in 1934, the MO “must preach the laws of health in and out of season”.⁷⁰

Although the multifarious rôle of the MO was stressed as being very ‘hands-on’, the amount of administration a MO had to undertake was quite considerable and the cause of many complaints (see Section 4.3). Duties included completing statistical returns, for their district, confidential reports on subordinate staff, stock-taking reports on medical supplies, an annual report on medical buildings and domestic medical quarters, as well as registers of pay, absence and ill health for all staff working in the district.⁷¹ As annual medical funding from the colonial government was based on the demand for medical services, it was the task of the MO to supply detailed (and preferably large) patient figures — “statistical obsession” which one MO cynically described as “the ten-fold propaganda value of ten circumcisions as against the unitary

⁶⁸ Unlike the French Colonial Medical Service which had employed Africans as *aides-médecins* since 1905, the British did not have any systematised training schemes for Africans until after World War One. Iliffe, *East African Doctors*, p.27

⁶⁹ Beck, *History of British Medical Administration*, p.147; DF Clyde, *History of the Medical Services of Tanganyika*, Dar Es Salaam, 1962, pp.77–8

⁷⁰ W Kauntze, ‘Memorandum on Departmental Policy’, Uganda Protectorate, *An.Med.Rep.*, 1934, Entebbe, 1935, pp.61–4, p.62

⁷¹ This is a list of the main paperwork; there were many more specific forms to fill out for all manner of procedures. FCO/14634 ‘Organisation of the Medical and Sanitary Services in the British Colonies: Replies to Circular Despatch: 1st February 1913’, *Standing Orders for the Medical Department* [Uganda], 1912, pp.6–10. In the later period as bureaucracy increased so did the paperwork.

significance of one hysterectomy”.⁷² MOs, just like other civil servants, were required to have a certain level of administrative expertise and numerical proficiency.⁷³ Indeed, by the 1930s administrative duties were so important that it was declared a “first prerequisite” to promotion to the senior grades. Those officers who felt that their talents lay in other areas were recommended to consider specialist or teaching posts if they wanted to be considered for promotion.⁷⁴

The ideal MO therefore espoused medical and surgical skill, management ability, educational interests, custodial duties and administrative proficiency. Personnel resources were never sufficient to allow for the luxury of exclusive specialisation before 1939. Even if the MO had ambitions, or even an official brief, to undertake specialist projects or detailed research on a particular medical phenomenon, these had to be fitted in with their core obligations. This makes it all the more remarkable that so many Colonial MOs contributed papers to East African and international research meetings (see Chapter 5). Aubrey Hodges’ 1905 complaint, when appointed to head the sleeping sickness investigations in Uganda, “more work for the same pay”⁷⁵, is just an early example of problems that later MOs encountered when they found that they were required to organise specialist investigations around all the regular duties of a MO.⁷⁶ Although the priorities of MOs were subject to change and adaptation (for example, the need to establish medical facilities in the first decades of British administration were supplanted by other concerns once the infrastructure was set up), the 1920s were a crucial turning point. From this time onwards, the focus of medical care shifted demographically (from providing healthcare only for European officials to the entire population), geographically (from focusing principally on urban areas to opening up rural ones) and in its medical focus (from curative medicine to public health). Furthermore, these changes, once made, became fundamental tenets of the job description that were to endure well beyond

⁷² Boase, ‘Reminiscences of Surgery’, p.198

⁷³ D Nell “For the Public Benefit’: Livestock Statistics and Expertise in the Late Nineteenth-Century Cape Colony, 1850–1900’ in S Dubow (ed.), *Science and Society in Southern Africa*, Manchester, 2000, pp.100–15, p.101–2

⁷⁴ Kauntze, ‘Memorandum on Departmental Policy’, p.64

⁷⁵ RHL/MSS.Afr.s.1782, Hodges, Diaries, 27/11/1905

⁷⁶ RHL/MSS.Afr.s.1872/153a Williams, ‘Detailed Memoranda’, p.6(a)

World War Two.⁷⁷ To understand the context of these changes in the job responsibility it is necessary to describe the way medicine was administratively ordered by the British in the East African Region.

4.2 The Organisation and Focus of Colonial Medicine

The way colonial medicine was organised within the period directly reflected changes in the focus of medical care and the expanding needs of the colonies. The practical organisation of the medical department, the rôle of its employees, and the policies it espoused were all interrelated facets of the different stages of establishment, development and, eventually, solidification of colonial medical administration in British East Africa. Broadly speaking, the history of colonial medical administration before 1939 can be divided into two distinct phases. The first stage (1893–1919) represented the period when the British presence in Kenya and Uganda was established. Government medical care during these formative years was organised principally for the benefit of the official European communities and when offered to Africans, it was usually to those in European employment. The focus of medical administration tended to be one of health crisis management. Attempts to combat major epidemics had the aim of stabilising British rule, rather than contributing to the welfare of African communities. During the first years of civilian rule in Kenya and Uganda, the provision of curative medical services and the establishment of basic facilities took precedence over wider medical aims. In stark contrast the second stage (1920–1939) marked a period of increased conviction that colonial rule in East Africa was likely to be around for some time. Medical departmental policies were significantly rethought in three major ways: first, there was a shift away from curative medicine towards preventive medicine; second, a complete overhaul of the medical administration was undertaken, moving towards a more decentralised system with responsibilities accorded to native authorities and provision made for rural African communities; and third, the first moves were made towards the official support of research medicine and the early development of specialisation. When

⁷⁷ RHL/MSS.Afr.s.1872/82 JK Hunter, 'Duties of [a] District Medical Officer'; 'Duties of a Provincial Medical Officer', 1951

Tanzania joined the British Empire the changes it underwent were more the result of these policy shifts than symptoms typical of the establishment of British rule.

As described in Chapter 1, the earliest incarnation of the Colonial Medical Service in Kenya and Uganda came directly out of the Imperial British East Africa Company (IBEAC). In 1895, when the company was officially disbanded, many IBEAC doctors transferred from company employment to government service and medical employees from the Uganda railway later joined them (see pp.22–4). In this period when medical policies were first demarcated and procedures and job descriptions were defined.⁷⁸ The organisational model for the running of the Colonial Medical Service in East Africa was broadly provided by the WAMS, but medical administration in Kenya and Uganda did not, initially at least, have an equivalent organizational infrastructure on which to build. In 1928, former PMO of Kenya, Milne, described the early organisation of the Colonial Medical Service in East Africa. Everything had to be established from first principles, making it extremely difficult for those stationed there.⁷⁹ Perhaps most cumbersome of all to the administration was the lack of delegation that the bureaucracy allowed for. With relatively few SMOs during the pre-war years, all MOs reported back through the same single hierarchical channel. In the early days the opinions of the widely dispersed medical staff were canvassed by central government through circular letters that usually asked a single question of all officers and then compared the different responses once they had been received.⁸⁰ Although attempts were made to improve and coordinate the medical services, the fundamental problem of short staffing and the need to establish a basic infrastructure took precedence over all else before the end of World War One.⁸¹

⁷⁸ KNA/MOH/1/1287 W Radford to PMO [asking for formalisation of his duties and precise explanation of what they entailed], Nairobi, 1906; KNA/MOH/1/5664 R Small to PMO, Nairobi, 13/01/1910; for examples illustrating the formulation of the job descriptions of the senior positions see KNA/MOH/1/8218 A Milne, 'Duties of the DPMO and DPSO', 12/02/1914

⁷⁹ AD Milne 'The Rise of the Colonial Medical Service', *KEAMJ*, 5, 1928–9, pp.50–8, p.54

⁸⁰ KNA/MOH/1/1497 'Medical Building Requirements' [Responses to a circular], 14/09/1906; KNA/MOH/1/5643A 'Return on question of Private Practice' 05–06/1915

⁸¹ PRO/CO/533/203 Minute: Bottomley, 24/06/1918

A fundamental change in Medical Department orientation was the movement towards preventive medicine. Although (as Beck has argued) this chiefly got underway in the period after 1920, crucial inroads were made into the subject before the war.⁸² The importance of the early township ordinances leading to the first Public Health Ordinance in 1913 have already been mentioned; it is valuable also to acknowledge the changing of attitudes towards public health in non-legalistic ways. Most significantly, the metropolitan-based push for sanitary improvements in the colonies was met with approval by medical departmental staff in East Africa. Subsequent delays in implementing the suggestions were more to do with limited resources than any lack of will or concordance.⁸³ Furthermore, because priority had to be afforded to issues integral to the establishment of colonial rule, most early initiatives towards sanitary reform were almost exclusively limited to urban areas before 1919.

Since the beginning of the century, medical opinion was largely unified in its acknowledgment of the pivotal function public health issues had in the future of the colonies.⁸⁴ The government in London declared its support for the ideas and agreed the need to “look to, and depend more on, prophylaxis than on cure” within the realms of colonial medicine.⁸⁵ These priorities were reflected relatively quickly within the colonial context. In 1904 the first post of Health Officer (HO) was instituted in Kenya, with Walter Macdonald as the first incumbent.⁸⁶ Soon after William Radford was made a MOH and became one of the first vocal campaigners for the East African public health cause. He frequently wrote to medical headquarters to express his dissatisfaction with the overburdened nature of his job and argued the need for concerted sanitary campaigns.⁸⁷ By 1910, Uganda had

⁸² Beck, *History of British Medical Administration*, p.48

⁸³ RHL/MSS.Afr.s.ff.312-321, D Donald, Letter, 06/10/1900; RHL/MSS.Afr.s.1091, Papers of CJ Baker, Baker to his Father, 23/11/1913

⁸⁴ R Ross, ‘Some Suggestions for the Improvement of Sanitary and Medical Practice in the Tropics’, *BMJ*, ii, 1900, pp.553-4; F Fremantle, ‘The Colonial Conference’, *BMJ*, i, 1907, p.536; ‘The Future of Tropical Medicine’, *BMJ*, i, 1909, p.1545

⁸⁵ ‘Tropical Medicine’, *BMJ*, ii, 1912, pp.40-2, p.40; see also ‘Sanitary Organization in the Tropics’, *BMJ*, ii, 1913, pp.377-9

⁸⁶ PRO/CO/543/3 EAP Bl.Bk., 1903-4

⁸⁷ KNA/MOH/1/1287 W Radford, ‘Correspondence over the Sanitary Condition of Nairobi’, 1906

established a separate sanitary branch of its Medical Department and the medical secretariat in Nairobi was also agitating for change.⁸⁸

A new phase of awareness of preventive issues within the British medical administration can really be dated to 1913 with the visit to Kenya and Uganda of William Simpson, public health advisor to the British Government. Simpson's recommendations were so important that they formed, *verbatim*, the basis of the subsequent Public Health Ordinance.⁸⁹ His recommendations included a call for the formation of a separate sanitary branch of the Medical Department in Kenya, where it had not yet been created, the re-organisation of urban areas, and the appointment and training of sanitary superintendents. Yet, although these proposals were embraced in principle, the systematic introduction of public health reforms was severely disrupted by the outbreak of the First World War, and change did not occur until the 1920s. From this time preventive campaigns were led by Gilks and Paterson in Kenya⁹⁰ and by Shircore, who installed numerous sanitary superintendents for lower-level public health work in Tanzania.⁹¹ In Uganda, the appointment of de Boer as DDMS in 1933 had a great influence on the development of public health awareness. De Boer was said to have converted "not only the Medical Department but the entire Administration to the gospel of environmental health".⁹²

Increased bureaucracy of the Medical Department and new legislation underpinned the new public health rôle of MOs. By the beginning of the First World War both Kenya and Uganda had split their medical administration into separate sanitary and medical branches as well as creating more senior positions within public health, such as CSO. When Tanzania joined the British Empire

⁸⁸ East Africa Protectorate, *An.Med.Rep.*, 1911, 1912, p.7, p.12, p.15, p.17, pp.21-9

⁸⁹ KNA/MOH/1/1231 'Professor Simpson's Report on Mombassa Sanitation and Other Correspondence', 1913; See also WJ Simpson, *African No.1025: Report on Sanitary Matters in the East Africa Protectorate, Uganda and Zanzibar*, 1915; East Africa Protectorate, *An.Med.Rep.*, 1913, 1914, p.18

⁹⁰ Beck, *History of British Medical Administration*, p.147; see also RHL/MSS.Afr.s.1653, TF Anderson, *Reminiscences by T Farnworth Anderson*, Book I, Kenya, 1973, p.49; See also RHL/MSS.Afr.s.1872/144a HC Trowell, 'Detailed Memorandum on Service as a Medical Officer, Lecturer in Medicine and Specialist Physician in Kenya and Uganda, 1929-57', [n.d. c.1984], p.5

⁹¹ Clyde, *History of the Medical Services of Tanganyika*, p.117; RHL/MSS.Afr.s.2032 WV Kendall, 'Extracts from the Diaries, Letters and Memory of WV Kendall whilst Serving in the Colonial Civil Service Uganda Protectorate 1922-1930'

⁹² RHL/MSS.Afr.s.1872/9 Barrett, 'Memorandum on Experiences', p.9

officially in 1919, it too reflected these developments by quickly setting up a Medical Department split into clinical, sanitary and laboratory branches. As well as the PMO and DPMO, a Senior Sanitary (later Sanitation) Officer (SSO) was appointed together with a strong contingent of non-medically qualified European sanitary superintendents.⁹³

More attention came to be focused upon the organisation of the Medical Service. The favoured system was one in which medical districts were overseen, whenever possible, by an SMO who “directed and coordinated” the medical work of several districts within a single province.⁹⁴ Senior staff usually manned the most important stations with a few MOs, but in outlying areas MOs formed the basis of the local medical administration. Occasionally, a MO could be in charge of an entire district, especially in sparsely populated areas such as the remote Northern Frontier District of Kenya. More generally, the districts were divided up into smaller units, referred to as locations or stations.⁹⁵ In accordance with the policy of indirect rule, these stations were also meant to be loosely representative of tribal boundaries with the headman or chief of the relevant tribe acting as the principal spokesman for each station.⁹⁶ At each station, (the “basic units of the [medical] department”) the resident MO was assisted by sub-assistant surgeons, compounders and dressers.⁹⁷

The system of medical administration in operation from the 1920s was based upon close cooperation with the native authorities.⁹⁸ The MO was expected to meet regularly with local chiefs and elders and health information was disseminated and “confidence was slowly gained”⁹⁹ through weekly meetings called, in Kenya and Uganda, ‘baraza’. John Carman reminisced that it was at these regular meetings that

⁹³ *The CO List*, 1920, pp.404–5

⁹⁴ RHL/MSS.Afr.s.1872/153a Williams, ‘Detailed Memoranda’, p.6

⁹⁵ PRO/CO/737/5 ‘Establishment of Districts, Proclamation No.1, 1926’, *TT Gov.Gaz., Supplement*, 05/03/1926, pp.35–6; ‘Establishment of Provinces, 1926’, *TT Gov.Gaz., Supplement*, 05/03/1926, pp.37–8; Carman, *Medical History of Kenya*, pp.33–4

⁹⁶ *Ibid.*

⁹⁷ Maclean, ‘Medical Administration in the Tropics’, p.757

⁹⁸ This was an enduring feature. RS Ladkin, ‘The Medical Officer and Local Government’, *JAA*, 5, 1953, pp.21–30

⁹⁹ RHL/MSS.Afr.s.1653, Anderson, *Reminiscences*, Book I, p.21

an MO would “speak about anti-malarial measures, methods of preventing plague and sleeping sickness or matters concerning housing and general standards of living”.¹⁰⁰ This educational function was in existence before the administrative changes of the 1920s, but it was only after that time that the use of MOs as health propagandists was seen as central. It is difficult to gauge how successful these relationships with native authorities were. Hunter felt in Uganda that he had personally never had any difficulties and many others voiced the same opinions.¹⁰¹

As the MOs were based in the district stations with other British officials, rural health provision to outlying African communities was provided, from the 1920s onwards, by the introduction of dispensaries throughout British East Africa. The system had first been successfully tried in Uganda in the post war years and thereafter was applied to Kenya by Patrick Nunan (in 1920) and then Tanzania.¹⁰² Dispensaries provided in and out patient facilities and were under the charge of an African resident assistant, although a European MO paid regular visits to oversee and provide supplies, as well as deal with any problematic cases. Dispensaries were also “propaganda centres” for distributing public health advice.¹⁰³ Schemes for the development of the dispensary system, which really took off after 1926, were led in Uganda by Major Keane, in Tanzania by Shircore and Scott and by Gilks in Kenya.¹⁰⁴ 1920 was recognised as a turning point at the time; it was the year that Gilks took over the headship of the Medical Department of Kenya and plans were inaugurated to extend public health activities to, and establish hospitals in, the rural native reserves. It was also the year that the first plans were initiated in Kenya to make provision for the training of native Africans as subsidiary medical staff.¹⁰⁵

Each station had at least one dispensary, but usually several, which in turn were connected with a larger district hospital (by the 1930s most administrative

¹⁰⁰ The importance of barazas for health propaganda was stressed in Kauntze, ‘Memorandum on Departmental Policy’, p.63; see also Carman, *Medical History of Kenya*, p.34

¹⁰¹ RHL/MSS.Afr.s.1872/82 Hunter, ‘Detailed Memorandum’, p.15

¹⁰² Gilks, ‘The Medical Department and Health Organization’, p.347

¹⁰³ RHL/MSS.Afr.s.1653, Anderson, *Reminiscences*, Book I, p.40

¹⁰⁴ Beck, *History of British Medical Administration*, pp.131–5

¹⁰⁵ Under Gilks leadership, 1920–32, fourteen medical units were established in the reserves and “over one hundred” dispensaries. Kenya Colony and Protectorate, *An.Med.Rep.*, 1932, Nairobi, 1934, pp.1–3, p.2

districts usually had a small hospital). Notwithstanding the popularity of the dispensary scheme, many of the plans to expand rural treatment centres were not implemented, and a formally organised official system of rural healthcare centres was not established until 1946.¹⁰⁶

One of the ways MOs managed these dispensaries and surveyed their districts was through regular, often arduous, 'medical safaris'.¹⁰⁷ Routine medical duties during such a safari included "get[ting] round...dispensaries as often as possible, inspecting their work records, replenishing their stores, and possibly helping with or evacuating special cases".¹⁰⁸ As well as overseeing the day-to-day healthcare of the residential population, DMOs often went on safari with a specific brief to investigate and quantify incidences of a disease.¹⁰⁹ These medical surveys were a frequent feature of duties right through the period, even before the large-scale establishment of dispensaries. They provided the means through which the central administration collected data on the medical profile of the country.¹¹⁰

From the 1920s schemes to train Africans for lower grade medical work were a crucial part of the decentralisation policy and were crucial for the growth of the dispensary system.¹¹¹ These 'tribal dressers' were African healthcare workers who, with some basic training, were responsible for running the many rural dispensaries. The training of Africans did not really take off in Kenya until 1926,¹¹² but the scheme

¹⁰⁶ A Beck, *Medicine, Tradition and Development in Kenya and Tanzania, 1920–1970*, Waltham, MA, 1981, p.15

¹⁰⁷ For a detailed example of a medical safari see JL Gilks, 'A Medical Safari in a Native Reserve', *KMJ*, 1, 1924–5, pp.270–4

¹⁰⁸ RHL/MSS.Afr.s.1872/33 ACE Cole, 'Memorandum on Experiences in the Colonial Medical Service in Tanganyika, 1939–60', 10/04/1983

¹⁰⁹ There were many, eg, Cole undertook a sleeping sickness survey in 1938. *Ibid.*; Rawson undertook a smallpox investigative safari in Uganda, 1923 RHL/MSS.Afr.s.1421, Papers of PH Rawson, Rawson to PMO, Entebbe, 31/03/1923. Carman was to investigate Yaws at Maseno, Kenya. Carman, *Medical History of Kenya*, p.33

¹¹⁰ By 1934 surveys were promoted as a means of disseminating western medical (especially public health) knowledge and gaining the influence of native inhabitants. Kauntze, 'Memorandum on Departmental Policy', p.61

¹¹¹ Although the bulk of change occurred after 1920, it is acknowledged that there were also some earlier moves towards promoting Africans as hospital dispensers, eg, J Thomson agitated over the issue. PRO/CO/533/210 'Evidence of Dr James Hutcheon Thomson to the East Africa Protectorate Economic Commission', enclosure Northey to Milner, 05/06/1919

¹¹² GO Ndege, *Health State and Society in Kenya*, Rochester, 2001, p.81

was first organized in the 1920s in Uganda (under Major Keane¹¹³) and Tanzania (under Davey and Shircore).¹¹⁴ It was in Uganda that this project had the most success and Mulago became the centre of medical training for Africans, eventually, in 1964, to full (MB, ChB) degree level.¹¹⁵

This type of medical administration was not problem-free. It still largely relied upon local administrations reporting back to the centre so that initiatives were usually confined to local levels and it remained difficult effectively to centralise policy or to implement country-wide health initiatives.¹¹⁶ Criticisms were still being made of the administration well into the 1930s, when it was felt that the medical services lacked coordination with disparate officers in outlying districts all reporting back at different rates and on different matters to a single authority. This, some argued, acted as a “serious deterrent to organised progress” — particularly the implementation of wider reaching development initiatives.¹¹⁷

The first systematic encouragement of research and specialisation emerged towards the end of the period. MOs had actively engaged in research as part of their routine duties from early times, through collecting local disease data in medical safaris or through their own field investigations for postgraduate medical qualifications, but earmarked funding and facilities were conspicuously absent. As early as 1903 Sir Michael Foster, Secretary of the Royal Society, called upon the Secretary of State to support colonial medical research (especially into malaria and blackwater fever) financially and administratively.¹¹⁸ A fundamental stumbling block to progress was the lack of even basic research facilities within the East African colonies. Even though the first bacteriologist, Philip Ross, was appointed to the EAMS in 1903 (a specialist position that was paid at a higher rate than the other MOs),¹¹⁹ it was some

¹¹³ G Keane, ‘Review of Native Medical Services for 1924’ in Uganda Protectorate, *An.Med.Rep.*, 1924, Entebbe, 1925, pp.62–4

¹¹⁴ WL/CMAC/MS/5677/1 J Davey, Private Papers, ‘British Administration in Tanganyika’, 1944, p.27

¹¹⁵ Iliffe, *East African Doctors*, p.103

¹¹⁶ Maclean, ‘Medical Administration in the Tropics’, p.757

¹¹⁷ ‘Editorial’, *EAMJ*, 9, 1932–3, p.339

¹¹⁸ Beck, *History of British Medical Administration*, pp.174–5

¹¹⁹ PRO/CO/543/3 East Africa Protectorate Bl.Bk, 1903–4

time before laboratory services achieved equivalent status to the clinical or sanitary branches of colonial medicine.¹²⁰ In Kenya and Uganda laboratory facilities were first arranged as a separate division of the Medical Department in 1915.¹²¹ In Tanzania, the British inherited relatively developed laboratory facilities set up by prominent researchers, such as Robert Koch and Friedrich Karl Kleine.¹²² A separate laboratory division was therefore established in British Tanzania right from the start. Despite this promising precedent, research was simply not prominent enough on the British colonial medical agenda to allow for many concerted subsequent developments, especially given the disruptions of the war and later strains on colonial budgets during the depression of the 1930s. Research all too often suffered through lack of central funding and was only really given premium attention after the Second World War.¹²³

This did not mean that no earlier pressures for change existed. MOs themselves seemed keen to push for more colonially based research facilities. Among improvements called for in 1919 by the departmental committee set up to consider the condition of the Colonial Medical Services under the chairmanship of Sir Walter Egerton, were study leave for MOs, the development of research services and an increased number of specialist appointments.¹²⁴ From the 1920s research in the colonies became a topic of parliamentary debate.¹²⁵ In Kenya in 1924, doctors involved in research, many of whom were colonial medical staff, submitted a formal memorandum petitioning the chairman of a visiting Royal Commission for greater recognition of the problems facing research-orientated doctors. They complained that there was a “very great lack of appreciation of such scientific work” and that the

¹²⁰ Despite a high profile visit to Uganda in 1906 of Robert Koch KNA/MOH/1/5898 ‘Visit of Dr Koch’, 07/06/1906

¹²¹ East Africa Protectorate, *An.Med.Rep.*, 1915, 1916, p.9; *The CO List*, 1915, p.403

¹²² Clyde, *History of the Medical Services of Tanganyika*, pp.28–32; p.102; Ross in Africa is dealt with in P Cranfield, *Science and Empire: East Coast Fever in Rhodesia and the Transvaal*, *History of East Coast Fever* Cambridge, 2002 [1991]

¹²³ Beck has gone so far as to say that little time or money were invested in research until the 1950s. A Beck, ‘The State and Medical Research: British Government Policy Toward Tropical Medicine in East Africa’, *Proceedings of the XXIII International Congress of the History of Medicine*, Vol.1, 1974, pp.488–93

¹²⁴ ‘Medical Appointments Under the Colonial Office’, *BMJ*, ii, 1923, pp.394–6, p.395

¹²⁵ ‘Tropical Medicine’, *BMJ*, ii, 1925, p.235; also ‘A Health Department for the Colonial Office’, *BMJ*, ii, 1925, p.267

chronic inadequacy of staff, combined with the lack of centralised cooperation and unsuitable laboratory facilities, made it was very difficult to conduct any serious scientific research.¹²⁶ By the second half of the 1920s there were even calls for the establishment of a Colonial Medical Research Service.¹²⁷ Conferences on the Coordination of Medical Research, were held in the three territories in 1933 and 1936, but various other priorities always seemed to be more immediately pressing, such as the need for more medical manpower, better hospital facilities and increased funding for training programmes for Africans. The result was that the East African Bureau of Research in Medicine and Hygiene was not established until 1949 with former MO in Kenya, Kenneth Martin as its director. Beck identifies this organisation as marking the first serious movement towards state-sponsored medical research in East Africa.¹²⁸

In the mid 1930s specialism in medical appointments was firmly on the agenda and gradually the number of available specialist medical positions began to grow. These included the appointment of the first ophthalmic specialist, Harley-Mason, in Kenya in 1937,¹²⁹ and Braimbridge, the first surgical specialist in Kenya in 1934.¹³⁰ The rhetoric of recruitment had changed to incorporate these new opportunities. A 1935 CO pamphlet outlined the sorts of specialist and laboratory opportunities open to new recruits in each territory and proclaimed the policy that Colonial MOs would be “encouraged to undertake postgraduate study, encouraged both financially and by the grant of study leave.”¹³¹ The new rhetoric was one of mutual benefit through personal development.

The policy is to develop any natural bent or special knowledge possessed by newly joined officers and wherever possible to place them

¹²⁶ KNA/MOH/1/8093 ‘Memorandum on Scientific Research in Kenya’, 12/1924

¹²⁷ ‘The Colonial Conference’, *BMJ*, i, 1927, p.1040. This eventually occurred in 1945.

¹²⁸ Beck, *History of British Medical Administration*, pp.183–90

¹²⁹ ‘Robert Harley-Mason’, *EAMJ*, 54, 1977, p.513

¹³⁰ ‘Clifford Braimbridge’, *EAMJ*, 41, 1964, p.31

¹³¹ AGH Smart, ‘An Impression of Life in the Colonial Medical Service’, *St. THG*, 37, 1939, pp.123–6, p.124

to the best advantage, keeping in mind their own interests as well as their usefulness to the service.¹³²

Changes in the organisation and focus of the medical departments were part of the developments occurring in the European administration all over British East Africa as it sought first to establish and then to consolidate its position. Between 1893 and 1919 medical administration developed with few formally developed central policies, personnel were mainly placed for European convenience and a single hierarchy ran all administration. Attempts had been made from 1913 onwards to broaden the remit of medical care, but these plans had to wait for the period of greater stability after the end of World War One to come to fruition. It was this next period that saw the most concerted moves towards change. In the medical sphere at least, decentralisation and application of the precepts of indirect rule were attempts to create an infrastructure to cope with more facets and levels of healthcare within such large geographical areas.¹³³

One of the major reasons why concerted attempts to foster research and specialisation were made only after 1930 was the power of curative medicine. The high incidence of disease meant that primary health care priorities swallowed up the scarce resources. Although the importance of preventive medicine had grown dramatically — to the point where it was regarded as the area to which the MO should devote “the major part of his attention”¹³⁴ — the striking, often instantaneous, impact of curative medicine meant that it was seen as a principal means through which the “confidence of the people must...be obtained”.¹³⁵

Medical departments naturally had to react on a day-to-day basis to the most pressing health needs of the country. Special initiatives were put in place for particular health emergencies. The focus of colonial medical administration, however, grew over time to accommodate both the increased expectations of colonial medicine with the need for bureaucratic workability. Eventually the duties of MOs

¹³² *Colonial Service Recruitment No.3*, p.35

¹³³ Gilks, ‘Proposed Expansion of the Medical Services’

¹³⁴ Kauntze, ‘Memorandum on Departmental Policy’, p.61

¹³⁵ East Africa Protectorate, *An.Med.Rep.*, 1919, 1920, p.18

developed, became broader and more standardised, while also adjusting to the need for specialisation by stratifying jobs and allocating the new ranks with special remits of responsibility.

4.3 Common Career Experiences

Official documents and personal reminiscence (memoirs, personal papers, obituaries), provide a wealth of evidence on features of the colonial career. The CO actively promoted the job by emphasising the considerable professional independence doctors could expect in Africa, compared to their medical equivalents in the UK (see Chapter 3). Less favourable images often emerge from the accounts of the doctors themselves. The job could be extremely pressured and overburdened; many MOs found colonial life very isolating, or felt frustrated in their medical efforts because of having to live and work in rudimentary facilities. Some MOs faced resistance or even outright hostility to their medical incursions and, despite medical progress, the job contained certain elements of risk to MOs' health and even lives. These unfavourable aspects of the career led to official action being taken by the BMA on the Colonial Medical Service's behalf.

* * *

Individual experiences naturally differed, but a first posting to East Africa generally followed a regular and established pattern. After appointment and successful completion of the DTM&H in the United Kingdom, new MOs were required to sail at the first available opportunity for Mombassa, or sometimes Dar Es Salaam, the ports of entry for the East Africa region.¹³⁶ Unless the officer was to be stationed at one of these ports, there then usually followed an extended overland trip to the capital city of the country of designation; after 1901 with the opening of the Uganda railway this would have been undertaken, at least partly, by train. Otherwise officers had to make the arduous journey overland usually with an entourage of native assistants with mules. After the 1920s things were made easier with the coming of motor cars to the region.

¹³⁶ Time was usually given (except in periods of staff shortages) for the candidate to terminate any other employment in which they may have been engaged. *Colonial Service Recruitment No.3*, p.8

The first weeks of official work were commonly spent in a capital city, or at least significant urban centre; often in one of the major hospitals to give the officer a gentle introduction to the territory; near to more experienced staff.¹³⁷ This initiation was as much social as professional, and it was during these early weeks that the new MO was introduced to colleagues and superiors within the Service and initiated into the codes and conduct of colonial behaviour (Chapter 5).¹³⁸ After this urban orientation the MO was given wider responsibilities, sometimes allocated to a specific hospital in an urban location, or, more commonly, sent out to a particular district, often with a brief to conduct a regional medical survey. There were examples, particularly before 1914, where new recruits were sent out immediately to remote areas, but by the post war period this practice was extremely rare and avoided wherever possible.¹³⁹

On a practical level, the newly arrived officer would be allocated a house (furnished by the Public Works Department), would typically acquire some form of transport, perhaps a bicycle or (in the later half of the period) a car, usually hire some local help (classically a cook and a house boy), start learning Swahili and perhaps supplement their supplies by a visit to the tropical outfitters.¹⁴⁰ With very little official initiation, other than a brief welcome meeting with a senior officer, professional life would formally begin.

* * *

¹³⁷ PRO/CO/822/94/12 R Scott, DMS Tanganyika to AJR O'Brien, Chief Medical Adviser to the CO, 18/05/1939. Egs: RHL/MSS.Afr.s.1872/9 Barrett, 'Memorandum on Experiences', p.1; RHL/MSS.Afr.s.1872/16 A Boase (compiled, RM Boase), 'Notes on Experiences in Colonial Medical Service in Uganda, 1924-56', 14/02/1983, p.1; RHL/MSS.Afr.s.1872/75 RS Hennessey, 'Learning About Disease in Uganda: 1929-44 and 1949-55', 1983, p.4; RHL/MSS.Afr.s.1872/24 HG Calwell, 'Memorandum on Experiences in the Colonial Medical Service in Tanganyika, 1930-49', 25/04/1983, p.4

¹³⁸ This same point is made for the ICS see DC Potter, 'The Shaping of Young Recruits in the Indian Civil Service', *IJPA*, 23, 1977, pp.875-89

¹³⁹ Gilks remembered his "feeling of helplessness" on being directly posted to a "remote station". Gilks, 'Proposed Expansion of the Medical Services', p.820

¹⁴⁰ For a description of getting settled in a new posting see RHL/MSS.Afr.s.1872/153a Williams, 'Detailed Memoranda', pp.5-6

Professional Independence

One of the most apparent features of the colonial medical experience was the amount of professional independence doctors were given. Staff-patient ratio “bore no relationship to UK levels” and MOs were often responsible for large districts with dispersed populations.¹⁴¹ In general, the exact definition of each individual’s job and responsibilities was never officially articulated, beyond a very broad brief that usually only stipulated that the MO should provide clinical and preventive medical care, and visit and survey the outlying areas of his district. Doctors in the field were largely left to their own devices to identify, adapt and coordinate their various responsibilities as best they could.¹⁴² There were relatively few restrictions and very little official monitoring of their activities. This experience was universal throughout the Colonial Medical Service regardless of where doctors were posted. As one MO stated “[o]ne is very much on one’s own and has to learn to be self-reliant and practical”.¹⁴³ Often early on in their careers, officers’ only tangible links to central government were the answering of intermittent circular despatches and the supply of the required monthly, quarterly and annual medical reports for submission to the central territorial bureaucracy. There were occasional inspection visits by senior staff, but even during the later period, when senior staff numbers were higher, these were described as unusual and infrequent.¹⁴⁴

Large districts meant a considerable degree of autonomy. George Maclean reminisced that in the early days of rule in Tanzania an MO “might find ...[themselves] responsible for the public health of a quarter of a million people, or even (although rarely) half a million people”.¹⁴⁵ Raymond Barrett recalled how he

¹⁴¹ RHL/MSS.Afr.s.1872/82 Hunter, ‘Detailed Memorandum’, p.19

¹⁴² MOHs had similar problems although not always as pronounced as DMOs. RHL/MSS.Afr.s.1653, Anderson, *Reminiscences*, Book I, p.49

¹⁴³ R St-Johnston, *Strange Places and Strange Peoples or Life in the Colonial Service*, 1936, p.28; Colonial Service doctors were not the only ones to find themselves in this elevated professional position abroad. Conscripted doctors were also described as having been able to experience “huge responsibility abroad, which a newly qualified doctor would never get at home”, JSG Blair, *The Conscript Doctors: Memories of National Service*, Durham, 2001, p.xii

¹⁴⁴ Carman, *Medical History of Kenya*, p.39

¹⁴⁵ Maclean, ‘Medical Administration in the Tropics’, p.756

was allocated a posting in Uganda in the late 1920s that was “the size of Yorkshire,”¹⁴⁶ and James Hunter similarly described his first district (West Mengo, Uganda) as having been “about the size of Wales”.¹⁴⁷ The experience was not an exclusively rural one. A single MO could find himself responsible for a variety of urban institutions — significantly more than a single doctor would ever be expected to supervise at home. In the late 1920s, for example, the MO in charge of the Native Hospital in Nairobi was also in charge of the mental hospital (Mathari) and the large down-town dispensary, not only supervising the patients, but also managing the accounts, supplies and personnel of these facilities.¹⁴⁸ Arthur Cole concisely summed up what must have been the feeling of many young colonial recruits — despite the great amount of administration to be done in outlying stations, the autonomy conferred upon young doctors also brought with it large advantages, not least the “certain amount of satisfaction in deciding one’s needs for staff, equipment, drugs and even buildings”.¹⁴⁹

Generalism and Versatility

Closely associated with increased independence was the wider professional remit Colonial MOs were likely to experience. This was an extremely common theme of accounts by officers reflecting on their careers, and was also highlighted by the CO as one of the most attractive job features. Given the meagre distribution of MOs compared to population needs, even during periods of recruitment boom, it is not surprising that the model MO was presented within the recruitment literature as generalist who could carry out a variety of medical procedures.¹⁵⁰ The successful MO needed to have the professional confidence and initiative to perform “every aspect of

¹⁴⁶ RHL/MSS.Afr.s.1872/9 Barrett, ‘Memorandum on Experiences’, p.2

¹⁴⁷ RHL/MSS.Afr.s.1872/82 Hunter, ‘Detailed Memorandum’, p.5

¹⁴⁸ Carman, *Medical History of Kenya*, p.12

¹⁴⁹ RHL/MSS.Afr.s.1872/33 Cole, ‘Memorandum on Experiences’. Although Cole is remembering 1949, the quotation holds true for his experiences during the earlier period.

¹⁵⁰ *Miscellaneous No.99*, 1921, p.3; This was reiterated in new editions of this pamphlet produced after the Warren Fisher Committee, where MOs’ work was described as “usually very varied”, *Colonial Service Recruitment No.3A: The Colonial Service. Information for the use of Candidates for Appointment to the Colonial Medical Service*, 1931, p.6

medicine in its widest sense”,¹⁵¹ and to possess leadership abilities, so as to manage staff within a large region and promote medical advantages to locals through methods of “persuasion and influence”.¹⁵²

Accounts by MOs support this official image. Arthur Boase reminisced how the job demanded that he be “as versatile as a Royal Marine Commando”. He described in his memoirs how his first Ugandan appointment in 1920 caused him daily to face a wide variety of medical problems from bubonic plague to strangulated hernia. In the colonies, “[t]he conjoint title of physician and surgeon was truly earned”.¹⁵³ Robert Hennessey likewise recalled his large early responsibilities. After only four months in service he was moved to a station in the Eastern Province of Uganda where staff shortages meant that he was immediately to take on the responsibilities of acting SMO.

So at the age of 24 I found myself responsible for the local anti-plague measures...detection and control of endemic disease outbreaks, maintenance of public health measures, general care of hospital patients (assisted by an Indian Sub-Assistant Surgeon), emergency surgery, supervision of district dispensaries and various odd jobs (such as attending an execution and certifying that life was extinct).¹⁵⁴

As the MO was frequently the only point of contact for western medical care in the region, the type of diseases and conditions officers were likely to deal with in the course of their careers were by no means restricted to ‘classic’ tropical diseases.¹⁵⁵ Furthermore, not only did the duties suppose wide clinical and surgical skills, but also the possession of basic laboratory abilities, so that MOs could perform simple analyses and microscopy to diagnose disease. Laboratory facilities were extremely scarce and problems of communication meant samples could not be easily processed remotely.¹⁵⁶

¹⁵¹ *Colonial Service Recruitment No.3*, p.35

¹⁵² Jeffries, *Partners For Progress*, p.66

¹⁵³ Boase, ‘Reminiscences of Surgery’, p.197

¹⁵⁴ RHL/MSS.Afr.s.1872/75 Hennessey, ‘Learning About Disease in Uganda’, p.5

¹⁵⁵ Especially before 1920. M Worboys, *Science and British Colonial Imperialism: 1895-1940*, University of Sussex, DPhil. Thesis, 1979, p.417

¹⁵⁶ Carman, *Medical History of Kenya*, pp.12-13; RHL/MSS.Afr.s.1872/82 Hunter, ‘Detailed Memorandum’, p.3

Diversity and adaptability was not only required in purely medical matters. One of the consistent elements of the career was the way it demanded skills far beyond the scope of those provided by even the broadest medical training — perhaps precisely why so much emphasis was put on character rather than qualifications during the recruitment process. At the beginning of British colonial rule in East Africa the MO needed to be a “Jack-of-all-trades” with “soldiering, administration, building and gardening” abilities.¹⁵⁷ But even by the end of the period, versatility was still advertised as one of the pre-requisites of the job. The successful MO was someone who displayed “adaptability and breadth of outlook, political ‘flair’ and what may be comprehensively described as the art of public relations, as well as pure professional competence”.¹⁵⁸

These broader spheres of activity were partly created by staff shortages. To support the basic infrastructure, MOs needed to be able to turn their hands to anything and be able to take on the wider duties that Beck has declared an integral part of a broader “social mandate” of MOs’ responsibilities.¹⁵⁹ As a symbol of the colonial order, the MO was intrinsically involved with social, economic and political structures of the regime. Beck saw the MO as “a social analyst...concerned...with education, town planning, and the art of political propaganda”.¹⁶⁰ This fits with a large body of evidence in which MOs described their involvement with local affairs, including the construction of new buildings, the presentation of detailed reports and the resolution of local disputes. This extension of the job was experienced at the more senior levels of the service too, with SMOs and their seniors often actively participating in some of the territorial government bodies.

...a senior officer of the Colonial Service is more than just a civil servant...He must have a seat in ‘Leg. Co.’ [Legislative Council], and even in ‘Ex. Co.’ [Executive Council] and he must therefore be something of a politician. He will have to take part in debate, explain and defend in the public the work for which he is responsible....He

¹⁵⁷ Foster, ‘Robert Moffat and the Beginnings of Government Medical Service’, p.240

¹⁵⁸ Jeffries, *Partners For Progress*, p.118

¹⁵⁹ Beck, *History of British Medical Administration*, p.137

¹⁶⁰ *Ibid.*, p.199

needs to have at his command all the art of diplomacy as well as ability in administration or skill in his own professional technique.¹⁶¹

Naturally, just as the actual breadth of the job depended upon an officer's rank in the service, the character of individual experiences was coloured by the location of a posting. As one commentator of the Colonial Service pointed out, "[s]ome men seem fitted by nature and interests for the bureaucratic life of secretariats; others chafe at urban living and thrive in the bush".¹⁶² The sort of duties an MO was likely to become involved with therefore were very place specific. An officer posted to the Northern Frontier district of Kenya (the isolated semi-arid region bordering with Ethiopia) needed to be prepared to defend his districts against border raids, so it was stipulated that service in this region approximated "active service" and required good soldiering ability.¹⁶³ In contrast, an officer posted to Mulago, Uganda, after the mid 1920s would invariably become involved with the medical school there and would find clinical and surgical duties supplemented by additional teaching commitments.¹⁶⁴

This necessity for generalism was regarded as a positive and rewarding aspect of the career.¹⁶⁵ Farnworth Anderson felt grateful that the experience had deterred him from any notions of specialisation he may otherwise have been persuaded to undertake.¹⁶⁶ The variety and emphasis upon every MO's own "initiative and judgement", was precisely one of the features that made the career so interesting.¹⁶⁷ Within the Colonial Service doctors could expect to achieve a "wider scope for the

¹⁶¹ Jeffries, *Partners For Progress*, p.65

¹⁶² R Heussler, 'An American Looks at the Colonial Service', *New Commonwealth*, 1960, pp.418-20, p.418; For a description of the European 'bush man' of colonial Africa see Kuklick, *Imperial Bureaucrat*, p.94, p.106; Eg. Corson preferred his location in the bush and rarely chose to venture into town. 'James Corson', *BMJ*, ii, 1963, p.1343

¹⁶³ *Colonial Service Recruitment No.3*, p.28

¹⁶⁴ Iliffe, *East African Doctors*, p.61. Also 'Report on the Uganda Medical School, Mulago for the year 1932', Uganda Protectorate, *An.Med.Rep.*, 1932, Entebbe, 1933, pp.68-72

¹⁶⁵ Although some officers naturally felt regret. Bagster Wilson was described as having been "disappointed" on appointment to public health work (he had wanted to be involved with surgery). RHL/MSS.Afr.s.1872/162(a) M Wilson, 'Memoirs of Service as Entomologist, Health Officer and Medical Officer in Tanganyika, 1933-63' [n.d.]

¹⁶⁶ RHL/MSS.Afr.s.1653, Anderson, *Reminiscences*, Book II, p.86

¹⁶⁷ Maclean, 'Medical Administration in the Tropics', p.757

exercise of their gifts than would be likely to come their way, unless they were exceptionally lucky, in the more settled conditions of home".¹⁶⁸

The Pace of Professional Life

If the different accounts of officers are to be believed, having a wide and varied job did not necessarily translate into having an unreasonably overburdened professional life. While some officers described situations where they were overworked and exhausted, others described a comparatively leisurely pace of life, occasionally even expressing frustration that they did not have enough work to fill their hours. The pace of professional life depended not only upon local conditions of each posting, but also on the personal initiative of individuals.

Whether MOs felt personally challenged for time or not, the perception of the medical departments was certainly that MOs *ought* to feel busy. One of the constant complaints emanating from the East African dependencies during the pre and the post-World War One periods centred on the lack of personnel and the consequent pressure upon those who were in post. Subsequent historical analysis too has related the slowness of development of interrelated fields; especially research, to the fact that doctors were excessively "overburdened" with practical duties to the sacrifice of longer-term medical projects.¹⁶⁹ In the early years the lack of resources, coupled with the relatively low profile of East Africa as a developing Colonial Service career, created considerable personnel pressures. The effects of the war only made things worse, with fewer people applying for Colonial Medical Service jobs than ever before.¹⁷⁰ Most PMOs despaired at the strains their respective medical departments had to bear. The amount of work a MO was expected to undertake in a district posting was, Gilks (PMO Kenya 1921–33) declared, "ridiculous": "no man could possibly undertake the variety of duties and responsibilities which were expected of Medical Officers".¹⁷¹ It was on the basis of these and like complaints, that the

¹⁶⁸ Jeffries, *Partners For Progress*, p.100

¹⁶⁹ A Beck, 'Problems of British Medical Administration in East Africa Between 1900–1930', *BHM*, 36, 1962, pp.275–83, p.277

¹⁷⁰ See Chapter 2, pp.74–81

¹⁷¹ Gilks, 'Proposed Expansion of the Medical Services', p.318

subsequent proposed personnel expansion of the medical services in East Africa of the mid 1920s was based.¹⁷² Similarly, one of the reasons given for recommendation to employ low-grade European Sanitary Officers in Uganda and Tanzania in 1925 was that it was thought increasingly “impracticable” as time went on, for MOs to deal with all their local curative and administrative duties as well as attending to preventive measures.¹⁷³

Personal evidence throughout the period supports this picture. A frequent cause of complaint centred on the regular medical safaris to oversee the running of rural dispensaries and provide help for patients needing specialist treatment. These trips were commonly described as being long and demanding, especially because many areas could be accessed only on foot; officers and their entourage were regularly underway for several days, occasionally even weeks, at a time.¹⁷⁴ This strenuous aspect of the job was realised by the CO who warned potential officers of these hardships in some of their later recruitment literature.¹⁷⁵ Despite the warnings complaints over “ceaseless travelling” became a defining feature of much reflection on medical safaris.¹⁷⁶ The pressures on time also meant that doctors regularly grumbled that they had little or no occasion for keeping up to date with new medical developments or expanding any areas of specialist interest they wanted to nurture.¹⁷⁷

Some MOs saw restrictions in more pecuniary terms as curtailing the amount of private practice they could potentially undertake. If official duties were too heavy the privilege of supplementing wages through attending to private patients became worthless. The right of MOs to undertake private practice was recognised throughout the period in East Africa, although the issue had always been thought to

¹⁷² *Ibid.*, Pressure was so great in Tanzania that Davey was called out of sick leave to take up the post of PMO Clyde, *History of the Medical Services of Tanganyika*, p.113

¹⁷³ Uganda Protectorate, *An.Med.Rep.*, 1925, Entebbe, 1926, p.48

¹⁷⁴ These long safari walks were typical. See the description of a one day 27 mile hike in Calwell, ‘Nineteen Years in the Colonial Medical Service’, p.(s)8. Also the 90 miles walked in two days by Wiggins. CA Wiggins, ‘Early Days in British East Africa and Uganda: Second Tour—1904–1907’, *EAMJ*, 37, 1960, pp.780–93, p.782; for a 40 mile walk in Uganda during the 1920s see RHL/MSS.Afr.s.1872/9 Barrett, ‘Memorandum on Experiences’, p.7

¹⁷⁵ *Colonial Service Recruitment No.3*, p.28

¹⁷⁶ Carman, *Medical History of Kenya*, p.35

¹⁷⁷ RHL/MSS.Afr.s.1378, Papers of BO Wilkin: *Annual Report of Dar Es Salaam*, 1935, p.1

be rather a “vexed question”¹⁷⁸ (see pp. 86–7). The amount of private practice government officers had depended mostly upon their location. In Kenya with its large settler community opportunities were quite numerous, especially in urban areas. In Tanzania the comparatively small British presence, combined with the numerous Indian Sub-Assistant surgeons competing on the private practice market, meant that opportunities were more limited.¹⁷⁹ A survey taken in Kenya in 1915, asking officers to supply information on the amount of private practice they undertook in their districts, revealed large differences between individual stations in a single country. While some officers replied that their official duties or isolated location precluded them from earning extra income, most reported some supplementary income derived in this way.¹⁸⁰ MOs with ostensibly large private practices often found that bills were frequently unpaid, undoubtedly because of the expectation that government doctors were meant to provide free health care.¹⁸¹ Accounts vary, but clearly sufficient officers had enough private practice to be vocally indignant when murmurings were made that the privilege might be taken away. Even if private practice meant that MOs’ time became even more pressured, most doctors were unwilling to let the opportunity of extra fees slip.

Another familiar cause of complaint was that staff shortages made it perpetually difficult to arrange leave. Many MOs grumbled about the long tours of service they were required to undertake.¹⁸² MOs were expected to travel a great deal to cover for colleagues who had resigned or been invalided out.¹⁸³ Officers frequently complained that they were not given any advance notice of transfers. As one PMO, Arthur Milne, of Kenya, explained, this was because of the constantly changing requirements of Colonial planning:

¹⁷⁸ ‘Organisation of the Colonial Medical Service’, *BMJ*, i, 1902, pp.347–8, p.348

¹⁷⁹ Some MOs still clearly made a significant living from private patients in Tanzania. See RHL/MSS.Afr.s.796, C Wilcocks, Diary, 1928–9, 17/05/1929, 01/06/1929

¹⁸⁰ KNA/MOH/1/5643A ‘Return on question of Private Practice’, J Thomson, 27/05/1915; R Spence, 28/05/1915; H Welch, 02/06/1915

¹⁸¹ Wiggins, ‘Early Days in British East Africa and Uganda: Second Tour’, p.785

¹⁸² For an extreme example of only nine months leave in eleven years see *Ibid.*, p.793

¹⁸³ Frequent regional tours were seen as a defining feature of indirect rule that relied on promoting good relationships between officers and Africans. Kuklick, *Imperial Bureaucrat*, p.68

[T]he conditions alter from six months to six months requiring a constant readjustment of the point of view; that the plan formulated say—in November is not the best arrangement to carry out when the officer returns [from leave] sometime in August of the next year. The experience of epidemics alone proves this.¹⁸⁴

Many memoirs reveal the frequency in which officers were expected to change their posting.¹⁸⁵ “The posting of MOs from district to district at unpredictable intervals was a disruptive feature of Colonial Service”.¹⁸⁶ This was because home leave, when granted was for several months, too long to leave an area unmanned. MOs had to be moved around “like pawns”. A process, critics maintained, that did not make for “efficiency or job satisfaction—or domestic contentment”.¹⁸⁷

By the time of Service unification in 1934 official policy recognised the advantages of maintaining a sense of continuity in the local setting, though paradoxically the reforms were intended to facilitate inter-territorial movements of staff. New MOs were reminded that they should acquaint themselves with their predecessor’s policies and not institute changes that could entail losing the confidence of the local community. Indeed, these considerations were so high on the agenda that in Uganda in 1934 it was made official that any MO wishing to start any new policy in his district would have to obtain specific sanction from head office to do so.¹⁸⁸

Not everyone had a hard life. Several MOs described how much free time they had and how their clinics were often empty rather than full. Most of the evidence for this relates to the period after the First World War, but if the early diary entries for Clement Baker and Aubrey Hodges are anything to go by, there was plenty of time to go on shooting expeditions, even mid-week.¹⁸⁹ Clare Wiggins similarly recalled how his MO duties at Kisumu in Kenya during the pre war era were “not heavy”; when he was not on medical safari, most of his duties were

¹⁸⁴ KNA/MOH/1/5065 ‘Appointment of Medical Officers: Procedure’, 13/03/1912

¹⁸⁵ RHL/MSS.Afr.s.1872/9 Barrett, ‘Memorandum on Experiences’

¹⁸⁶ RHL/MSS.Afr.s.1872/153a Williams, ‘Detailed Memoranda’, p.14

¹⁸⁷ *Ibid.*

¹⁸⁸ Kauntze, ‘Memorandum on Departmental Policy’, p.61

¹⁸⁹ RHL/MSS.Afr.s.1091, Papers of CJ Baker, Diary 1904, there are numerous examples of this. A random sample (all occurring significantly during the week rather than weekends!) could include 25/01/1904; 12/04/1904, 27/12/1904; also RHL/MSS.Afr.s.1782, Hodges, Diaries

completed by 10am each day.¹⁹⁰ The Great War, when many officers were commissioned into the East African forces, seemed especially to entail long periods of inaction, especially as officers were taken away from their regular duties and ordered to wait for casualties to arrive at the special military hospital camps. During this period in East Africa, Carpenter recalled how his peripatetic life as a Captain in the Uganda Medical Service was characterised more by boredom than by anything else.¹⁹¹

Evidence of the rather slow pace to professional life can be found throughout the period. Barrett described how during his 1935 posting he was “far from stretched in routine duties...there was no lack of time and opportunity for exploring this superb district in sightseeing and searching for big game”.¹⁹² As would be expected, however, the location of a posting in a largely determined its busyness. Hugh Trowell seemed to have experienced both extremes: while in Kenya, working at Machakos District Hospital in 1929, he was at first daunted by the task he was given as a new recruit responsible for all surgery in the hospital. His fears soon subsided: “I need not have worried, during my six months the ward had usually only three or four patients and not a single operation was called for”.¹⁹³ His next posting to Uganda, in contrast, appears to have been much busier — his description of the working day there offers a dramatic contrast to the experiences he originally had at Machakos.¹⁹⁴

Whether life as a MO was busy or not sometimes reflected local native perceptions of the medical services. Medical care was, of course, based on the western model and very little attention, if any, was given to local herbal remedies, variolation, ‘magical’ or voodoo customs, even though it was frequently acknowledged that this was would be most easily understood by the largest number

¹⁹⁰ CA Wiggins, ‘Early Days in British East Africa and Uganda’, *EAMJ*, 37, 1960, pp.699–708, p.703; Although he admitted that his district was often short-handed and when other staff went away, and he could be “DC. ADC and MO all at once” *ibid*, p.706

¹⁹¹ In fact it was these periods of boredom that encouraged Carpenter towards entomology. ‘GDH Carpenter’, *BMJ*, i, 1953, pp.406–7, p.406

¹⁹² RHL/MSS.Afr.s.1872/9 Barrett, ‘Memorandum on Experiences’, p.10

¹⁹³ RHL/MSS.Afr.s.1872/144a HC Trowell, ‘Detailed Memorandum on Service as a Medical Officer, Lecturer in Medicine and Specialist Physician in Kenya and Uganda, 1929–57’, [n.d. c.1984], p.3

¹⁹⁴ WL/CMAC/PP/HCT/A5 Bray, *Hugh Trowell: Pioneer Nutritionist*, [Chapter 9] p.8

of people.¹⁹⁵ The strength of indigenous medicine no doubt helps to explain the distinct lack of enthusiasm some doctors reported in response to their medical efforts for native populations. As late as the 1930s, doctors found antipathy, and sometimes even outright hostility, to treatment.¹⁹⁶ The lack of native interest in colonial medicine can be better understood when the coercive nature of some of the medical interventions are recognised.¹⁹⁷ Arthur Procter, for example, although proud of the success of his anti smallpox vaccination campaign at Fort Hall, Kenya in 1925, acknowledged that the vaccinations were carried out “often unwillingly and by force”.¹⁹⁸ Local resistance was usually displayed through non-attendance at clinics rather than through more aggressive action, although in one reported instance, a sanitary superintendent actually lost his left hand and part of his forearm in a native protest against enforced plague quarantine in the Luwere region of Uganda.¹⁹⁹ In general, opposition had diminished by the end of the period, with favourable reports of the reception of western medicine by African people outstripping unfavourable ones.²⁰⁰ By 1937 the Kenya Annual Medical Report announced that European medicine was “thoroughly established throughout the colony”.²⁰¹ Descriptions of “huge crowds” around clinics were more common than accounts of problems of persuading Africans of the efficacy of the western medicine.²⁰²

¹⁹⁵ Maclean, ‘Medical Administration in the Tropics’, p.756

¹⁹⁶ RHL/MSS.Afr.s.1872/144b HC Trowell, interviews, tape 1B, [n.d. c.1984], p.8; “A characteristic of the general population was a degree of apathy and even fatalism to illness and injury” RHL/MSS.Afr.s.1872/82 Hunter, ‘Detailed Memorandum’, p.5

¹⁹⁷ Ndege, *Health State and Society*, 2001; Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire 1900–1940*, Cambridge, 2002 [1992]; RM Packard, *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa*, Berkeley, CA, 1989

¹⁹⁸ RHL/MSS.Afr.s.702, RAW Procter, ‘Random Reminiscences, Mainly Surgical’, [n.d.], p.6; see also the account he related of Kikuyu resistance to his public health campaign, p.7

¹⁹⁹ RHL/MSS.Afr.s.2032, Kendall, ‘Extracts from Diaries, Letters and Memory’, p.6

²⁰⁰ Although it is acknowledged that it was in the interests of the British government to suppress reports of resistance and to favour positive accounts of the happy acceptance of western medicine in East Africa. Kenya, *An.Med.Rep.*, 1938–9, (*Abbreviated*), [n.d. c.1940], p.1

²⁰¹ Kenya, *An.Med.Rep.*, 1937, Nairobi, 1938, p.1

²⁰² RHL/MSS.Afr.s.1872/153a Williams, ‘Detailed Memoranda’, p.7

Difficulties and Risks

The difficult side of colonial medical life, though less publicised by the CO, was quite apparent to many practitioners, especially those who were posted to the districts.²⁰³ Life, especially in the bush, was sometimes isolated, usually difficult and often risky. Hugh Calwell remembered that mail arrived only once a week to his station, brought by a runner who had to travel for seventy-two hours. This made contact with the outside world very limited and letters from home very welcome indeed.²⁰⁴ It is in these terms, that the differences between rural and urban postings were most pronounced. Communications were better in the larger cities.²⁰⁵ In town there was a broader and more organised European community; and the opportunity for professional debate. Official duties could be shared if the need arose.²⁰⁶ Clearly, some MOs found district life difficult to grow accustomed to. Indeed this was common enough for the CO to adopt a policy by the 1930s of grouping colonial officials together in enclaves with other European officers nearby.²⁰⁷

All the personal reminiscences of colonial MOs mention the basic and primitive facilities that faced them on arrival to their post. Not only did the officer usually find that their own standard of living was considerably lower than he would expect at home, but also, that the medical facilities were sparse and rudimentary. The facilities that greeted many MOs on arrival to their stations often took even the most adventurous MOs aback. Farnworth Anderson was dismayed that his house in Teita District, Kenya (in the late 1920s) had a pit latrine, very little furniture and no bath, despite a stunning view.²⁰⁸ Wiggins similarly described his first impression upon

²⁰³ Furthermore, the danger was apparent to life insurance companies who were sometimes reluctant to offer policies to MOs destined to serve in Africa. Eg, MO Henderson described in Errol Trzebinski, *The Kenya Pioneers: the Frontiersmen of an Adopted Land*, 1991 [1985], p.45

²⁰⁴ Calwell, 'Nineteen Years in the Colonial Medical Service', p.(s)13

²⁰⁵ The Medical Department head offices were connected to the telephone exchange in Nairobi in 1909 KNA/MOH/1/5532 A Milne, PMO Nairobi to Superintendent of Telegraphs, 08/07/1909

²⁰⁶ Calwell's memoirs provide a nice description of the contrasts between these two types of posting. Calwell, 'Nineteen Years in the Colonial Medical Service'

²⁰⁷ [Re. Kenya] "It can be stated that Medical Officers are never posted at stations where there is no other European Society." *Colonial Service Recruitment No.3*, p.28. Similar statements pertaining to Uganda and Tanzania were also made *Ibid.*, pp.30-1, p.35

²⁰⁸ RHL/MSS.Afr.s.1653, Anderson, *Reminiscences*, Book I, p.23

arrival at Kisumu as being unimpressive: with only a “few grass thatched mud and wattle huts” constituting the Government’s headquarters.²⁰⁹

Perhaps most difficult for the most idealistic of doctors were the poor medical facilities in both urban and rural postings. Robert Small on arrival to Jubaland, Kenya, in the first years of the century was dismayed to find the European hospital practically “useless for its purpose”.²¹⁰ By the 1920s descriptions of the operating theatre in the same hospital reveal that, although conditions had no doubt improved, by modern European standards conditions were still very poor and trying for even the most confident surgeon.

The operating theatre was just an ordinary room with barely sufficient space to hold the operating table and two or three persons; there was no water laid on and everything ran on paraffin...there were only three of us who dealt with surgery, and when one was operating, another assisted and the third gave the anaesthetic. How terrified I was when I was the anaesthetist!²¹¹

Standards in native hospitals almost always lagged behind the European ones, so it is unsurprising that Trowell also was exasperated by the poor facilities at Nairobi Native Hospital when he was transferred there in 1930.²¹² One has to feel some sympathy at William Connell’s reaction upon reaching his posting in Songea, Tanzania in 1924:

Awful shock when I saw the hospital, a filthy old German building, full of rats and dirt. Conditions almost indescribable. The place had heretofore been run by ... a typical babu. Sanitation in Songea almost non-existent. Operating theatre filthy; so started by ordering it to be scrubbed out and whitewashed.²¹³

The following day he recorded that he felt “like crying over the condition of my hospital, which is a dingy hole with 40 horrible native beds”.²¹⁴ The dispensaries too regularly had very few medicines and medical supplies and even if an MO could get

²⁰⁹ Wiggins, ‘Early Days in British East Africa and Uganda’, p.702

²¹⁰ KNA/MOH/1/1497 R Small to PMO 1st April 1907

²¹¹ ‘Address by Mr CV Braimbridge’, *EAMJ*, 31, 1954, pp.205–8, p.205

²¹² RHL/MSS.Afr.s.1872/144a Trowell, ‘Detailed Memorandum’, p.6

²¹³ RHL/MSS.Afr.s.708 (1), WK Connell, Diary 1924–5, 02/10/1924, pp.23–4

²¹⁴ *Ibid.*, 03/10/1924, p.24

to patients, the use of intermittent or one-off treatments was regarded by many MOs as of little sustained effect.²¹⁵ “Distances were considerable”, the earth roads were “dubious” and the first dispensaries themselves were often only mud huts.²¹⁶ By the end of the period the situation had not improved as much as might be expected. Although there was much more of a physical infrastructure in place, MOs still bemoaned the “the lack of resources both human and material to provide more than an elementary ‘medical’ and ‘health promoting’ service”.²¹⁷ Even when initiatives were proposed they often had to be curtailed owing to lack of staff.²¹⁸ The scarce resources and comparative isolation meant that in practice officers had to call upon their own resourcefulness to adapt and experiment with what was (and was not) viable medical practice.

The very nature of work in the colonies meant that doctors were exposed, willingly or unwillingly, to dangerous tropical diseases. As the sick, invaliding and death rate returns for the annual medical reports reveal, there were risks in pursuing a career in Africa, but after 1900 these decreased. The chances of pursuing a long and healthy career to retirement age, if an officer so desired, were not as remote as they were before 1900. A few doctors in the service of the greater good used themselves as guinea pigs to further their research. James Corson twice infected himself with *Trypanosoma rhodesiense* during his research into sleeping sickness.²¹⁹ Many officers caught tropical diseases less willingly and as a result had to be, temporarily or permanently, invalided out of the Service.²²⁰ Illness was a persistent feature of colonial life. Aubrey Hodges, one of the first MOs in East Africa, recorded his numerous sicknesses and was one of the first of a long line of intermittently ailing

²¹⁵ RHL/MSS.Afr.s.1872/144a Trowell, ‘Detailed Memorandum’, p.4. This was not a problem unique to dispensaries, often medicines even if prescribed were not in stock. KNA/MOH/1/7438 W Radford to PMO, 10/07/1908

²¹⁶ RHL/MSS.Afr.s.1872/33 Cole, ‘Memorandum on Experiences’

²¹⁷ RHL/MSS.Afr.s.1872/82 Hunter, ‘Detailed Memorandum’, p.5

²¹⁸ RHL/MSS.Brit.Emp.r.4, PA Clearkin, *Ramblings and Recollections of a Colonial Doctor 1913–58*, Book I, Durban, 1967, pp.125–6

²¹⁹ Additional to having caught sleeping sickness twice before by accident. ‘JF Corson’, *Lancet*, ii, 1963, p.1073

²²⁰ Eg, Bödeker, Shircore and Ross from Kenya in 1913. East Africa Protectorate, *An.Med.Rep.*, 1913, 1914, p.13; or John Goodliffe in 1919. Uganda Protectorate, *An.Med.Rep.*, 1919, Entebbe, 1920, p.6

Colonial MOs.²²¹ Two of the most common problems appear to have been malaria and tick-borne fever, diseases that attacked all strata of society. Even if officers managed to escape serious illness, they often wrote of their accompanying wives being afflicted.²²²

Many MOs got so sick in the course of their duties that they were forced to retire: for example, Cyril Burges, Arthur Clanchy, Robert Hamilton, Alfred Mackie, Neil McLean, Joseph Ridgway, John Ross, Philip Ross, Douglas Scott, Kenneth Wallington and Charles Wilcocks.²²³ A significant number even died while in Service, often, but not always, from tropical diseases.²²⁴ A few passed away in more dramatic circumstances: Ralph Stoney died from an elephant attack in 1905; a buffalo killed Walter Densham in 1907.²²⁵

The strains put on bodily health by the tropical environment were not the only things that made doctoring in East Africa difficult. The psychological pressures of colonial life were also significant. The tropical climate had long been accepted as being more emotionally challenging than the temperate home environment.²²⁶ A survey in the *BMJ* that looked at the chief causes of invaliding for both members of the military and missionary professions found that nervous disorders, characterised at

²²¹ RHL/MSS.Afr.s.1782, Hodges, Diaries, 21/04/1900; 15/08/1901; Wiggins, 'Early Days in British East Africa and Uganda: Second Tour', pp.781–2; Calwell, 'Nineteen Years in the Colonial Medical Service', p.(s)20, p(s)33; RHL/MSS.Afr.s.1872/33 Cole, 'Memorandum on Experiences'; RHL/MSS.Afr.s.1872/162(a) Wilson, 'Memoirs of Service'

²²² RHL/MSS.Afr.s.1872/144b Trowell, tape 1B, p.12; RHL/MSS.Afr.s.1872/82 Hunter, 'Detailed Memorandum', p.22

²²³ 'Alfred Mackie', *BMJ*, ii, 1959, p.1262; 'Neil McLean', *BMJ*, i, 1955, p.917; KNA/MOH/1/4740 R Small to PMO, 31/01/1918; East Africa Protectorate, *An.Med.Rep.*, 1914, 1915, p.11; Kenya, *An.Med.Rep.*, 1928, Nairobi, 1929, p.56; Kenya, *An.Med.Rep.*, 1931, Nairobi, 1932, p.45; Uganda Protectorate, *An.Med.Rep.*, 1912, 1913, p.5; Uganda Protectorate, *An.Med.Rep.*, 1914, 1915, p.8; Uganda Protectorate, *An.Med.Rep.*, 1925, Entebbe, 1926, p.6; Uganda Protectorate, *An.Med.Rep.*, 1934 Entebbe, 1935, p.9; C Wilcocks, *A Tropical Doctor in Africa and London*, unpublished autobiography, Surrey, 1977, p.133

²²⁴ Eg, James Armstrong, Hugh Baker, Raymond Bury, John Caldwell, Bertham Cherrett, Walter Densham, John Edmond, Alfred Garde, William Heard, Edward Langton, Harold Mann, John O'Connell, Westmore Spence Forbes Tulloch and Karl Uffmann. There were undoubtedly others, this is a list gleaned principally from obituaries which make specific mention of the cause of death.

²²⁵ PRO/CO/457/6 'Obituary Dr Stoney', *EA&U Gov.Gaz.*, 15/11/1905, p.373; PRO/CO/457/7 'Obituary', *EA&U Gov.Gaz.*, 01/07/1907, p.232

²²⁶ R Havelock Charles, 'Discussion on Special Factors Influencing the Suitability of Europeans for Life in the Tropics', *BMJ*, ii, 1910, pp.869–74; Crown Agents for the Colonies, *Hints on the Preservation of Health in Tropical Africa*, 1943 [1938] See also M Harrison, *Climates and Constitutions: Health, Race, Environment and British Imperialism in India 1600–1850*, New Delhi, 1999

the time by the fashionable term, neurasthenia, surpassed systemic diseases as a cause of permanent invaliding.²²⁷ Officers who left the Colonial Medical Service because of mental breakdown (perhaps caused as much by the stresses of the job as those of the climate) included Peter Milne and Robert Small, who suffered from “anorexia, insomnia and a loss of mental control” caused by sunstroke.²²⁸ The position of PMO in Tanzania appeared to be particularly ill-fated. The first choice, Hugh Stannus was forced to step down soon after appointment for reasons of ill health. His successor, Arthur Horn, also had to leave before Tanzania officially came under British control in 1919, suffering from a mental breakdown.²²⁹ Even those who were not diagnosed as mentally sick sometimes complained about the routine stresses of their duties, which caused them to lose weight or suffer from persistently interrupted sleep.²³⁰ Attempts to find solace in narcotics were not looked on favourably by the establishment: Harvey Welch was sent home for becoming a drug addict; Ernest Adams also appears to have been involved in an addiction scandal and was invalided out of the service.²³¹

Other Common Complaints

Two common sources of discontent among MOs were low pay, with comparatively remote prospects for promotion, and excessive amount of paperwork associated with the job. Pay was a contentious issue that the CO often felt impelled to justify in terms of the other broader benefits offered by the career (see pp.82–5, 96–8). Throughout the period contemporary comments seem almost uniform in their bitter criticism of colonial medical salaries. An anonymous ‘observer’ of the EAMS described how “the pay of the Senior Medical Officers is quite inadequate and the prospects are nil”.²³² Furse admitted that although a single man could live sufficiently

²²⁷ ‘Discussion of the Causes of Invaliding from the Tropics’, *BMJ*, ii, 1913, pp.1290–6, p.1290; p.1294

²²⁸ RHL/MSS.Afr.s.1872/144a Trowell, ‘Detailed Memorandum’, p.8; KNA/MOH/1/4740 Case of R Small, 01/1918

²²⁹ Clyde, *History of the Medical Services of Tanganyika*, pp.99–100

²³⁰ RHL/MSS.Brit.Emp.r.4, Clearkin, *Ramblings and Recollections*, Book I, p.110

²³¹ “If Adams is addicted as suspected the sooner he goes the better”. KNA/MOH/1/1468 Commissioner, Entebbe to J Will, PMO, Uganda, 05/09/1905

²³² ‘The East African Medical Staff’, *BMJ*, i, 1910, p.177

well on a Colonial Medical Service salary in East Africa, a man wanting to bring his wife or family with him would “have to go very carefully indeed unless he has private means”.²³³ Combined with this, promotion opportunities were notoriously scarce.²³⁴ This led to the perception, by some at least (despite consistent CO claims to the contrary), that promotion within the Service was as much to do with the length of service as to the quality of individuals.²³⁵ It was not uncommon for officers to have served for over ten years before being promoted to the rank of SMO, and some officers served fifteen or even twenty years without promotion.²³⁶ When Davey was offered the PMO job in Tanzania, he came out of sick leave to take it up; before this he had not been promoted for seventeen years. Unsurprisingly, he felt he “could not afford to let this chance go”.²³⁷ Complaints about salary and prospects were so pronounced that the BMA conducted a campaign for improvement on the Colonial Medical Service’s behalf (see below). Attempts were made to reform the amount of administration Colonial MOs were expected to undertake quite early on.²³⁸ In 1903 a report was circulated to all colonial governors relating recommendations made by Manson (originally prepared in 1900) over the improvement of medical reports, especially through standardizing their presentation and content.²³⁹ MOs still routinely claimed, however, that administration took up inordinate amounts of time. They often found themselves simultaneously having to work on the annual report and the monthly report, as well as compiling local statistics of patient numbers, length of stay and medical profiles, for the blue book returns.²⁴⁰ Gradual improvements were made towards standardising and reducing medical reporting, but

²³³ PRO/CO/877/2/6370 Furse to R Falconer, 24/04/1922

²³⁴ “The chief drawback to the Colonial Medical Service appears to be the uncertainty of promotion”, ‘The Colonial Medical Service’, *BMJ*, i, 1899, p.323

²³⁵ RHL/MSS.Afr.s.1872/16 Boase, ‘Notes on Experiences’, p.2

²³⁶ RHL/MSS.Afr.s.1872/82 Hunter, ‘Detailed Memorandum’, p.10

²³⁷ Clyde, *History of the Medical Services of Tanganyika*, p.113

²³⁸ RHL/MSS.Afr.s.1653, Anderson, *Reminiscences*, Book I, p.52

²³⁹ Chamberlain to Governors of all Colonies, ‘Papers Relating to the Investigation of Malaria and Other Tropical Diseases and the Establishment of Schools of Tropical Medicine,’ *Parliamentary Papers*, 1903, 44, pp.3–5

²⁴⁰ RHL/ MSS.Afr.s.796, C Wilcocks, Diary, 1928–9, 04/12/1928; 08/01/1929; 14/01/1929; 02/02/1929

complaints continued throughout the 1930s.²⁴¹ The load was considered so oppressive that it was claimed that it interfered with clinical duties and wives were occasionally drawn in informally to assist with the administrative burden.²⁴²

The rôle of the British Medical Association

From the 1890s onwards the structure and organization of the Colonial Medical Service was often challenged by external commentators as well as its employees. As the career path solidified, this *ad hoc* questioning of its fundamental purpose was replaced by more specific cavils (emanating almost exclusively from within the Service) over the terms and conditions of employment.²⁴³ Dissatisfaction became much more organised during the twenties and thirties. During this later period East African branches of the BMA vigorously lobbied the CO for improvement and reform of the EAMS.²⁴⁴ As the primary channel through which medical professionals in the colonies could appeal directly to the BMA in London, these regional divisions were important in uniting widely dispersed groups of medical practitioners under a single umbrella organisation (Chapter 5). Prominent senior East African MOs actively collaborated via their local BMA divisions with the BMA in London to improve their terms of service.²⁴⁵ The BMA campaigned for improvements in the terms and conditions of employment, most importantly through publishing demands for reform in the influential *BMJ*. Three periods of concerted campaigning for change were conducted by members of the metropolitan BMA:

²⁴¹ PRO/CO/323/1461/13 'Infectious Diseases: Recommendations of East Africa Directors of Medical Services for Standard Form of Weekly Report', 1937. Concerted moves towards improvements in the 1930s were aided by discussions over the nature of medical reporting in general. Eg, G Edge, 'The Contents of Colonial Medical Reports', *EAMJ*, 14, 1937-8, pp.146-7

²⁴² See p.182 ; RHL/MSS.Afr.s.1872/82 Hunter, 'Detailed Memorandum', p.6, p.26

²⁴³ Some early criticisms over the way the service was to be organised can be found in G Evatt, 'Notes on the Organisation of the Colonial Medical Service of the Empire', *BMJ*, ii, 1896, p.864; 'The Colonial Medical Service: A Rejoinder', *BMJ*, i, 1897, p.216; 'Correspondence: The Colonial Medical Service', *BMJ*, ii, 1899, pp.1479-80; PRO/CO/323/437/9829, 'Colonial Medical Service', 05/1898, pp.242-4; S Squire Sprigge, *Medicine and the Public*, 1905. For examples of specific criticisms over terms and conditions see p.173

²⁴⁴ The Kenya and Uganda branches were formed in 1920, closely followed by the establishment of a branch in Tanzania in 1923. See also TJ Johnson and M Caygill, 'The British Medical Association and its Overseas Branches: A Short History', *JICH*, 1, 1973, pp.304-29

²⁴⁵ Gilks and Patterson were on the Dominions Committee of the BMA in its discussions over Colonial Office terms and conditions of service in 1936. PRO/CO/850/71/13 'Deputation by the BMA, 1936'

- i. 1919–21 when the BMA petitioned the Colonial Medical Services Committee of the CO on behalf of its East African members;
- ii. 1925–26 when it made specific remonstrations over the terms of the new EAMS regulations (*African (East)* No.1103, published March 1925);
- iii. a wider protest around 1936 that called for improved terms for the Colonial Medical Service in general.²⁴⁶

Dissatisfaction was sometimes expressed through the official reports that MOs and their seniors submitted to the central medical departments, but these complaints did not have the political leverage and bargaining power of the more centralised protests organised by the BMA.²⁴⁷ On several occasions the BMA used the threat of withholding advertisements for the Colonial Medical Service or warnings that it would publish negative reports on the career, as bargaining points for improvement.²⁴⁸ In 1926, when the right of MOs to private practice was under threat, an explicit warning against the Colonial Medical Service as a career for young graduate doctors was published in the *BMJ*.²⁴⁹ Central government was quite aware of the significance of the BMA in influencing medical opinion and Furse noted the “considerable importance” of keeping the Association onside as an aid to recruitment.²⁵⁰ In a series of editorials and letters in the *BMJ*, the BMA asserted that the poor conditions of service actually discouraged the best doctors from taking up the career. Although this raised the profile and urgency of perceived problems within the Service, it was very much a double-edged sword. The criticisms risked

²⁴⁶ BMA/C/1/4 ‘Annual Reports of UK and Overseas Branches 1930-1937’; BMA/E/1/41 Colonial Medical Services, 1919-1950’; BMA/B/162 ‘Dominions Committee [originally the Colonial Committee] 1909-1952’

²⁴⁷ C Wiggins, ‘Report to the Medical and Sanitary Advisory Board to the Colonial Office.’ 08/12/1919, SMP/5968/UNA, p.13 quoted in Beck, *History of British Medical Administration*, p.58, p.66

²⁴⁸ ‘Colonial Medical Services: Report of the Departmental Committee’, *BMJ*, ii, 1920, pp.448–9; ‘Memorandum of Evidence Placed by the BMA Before the Colonial Medical Services Committee, 23/02/1920’, *BMJ, Supplement*, 1920, pp.141–3

²⁴⁹ ‘The Colonial Medical Services: Statement by the BMA’, *BMJ, Supplement*, 1926, pp.9–10; ‘Regulations for the East African Medical Service, Correspondence Between the BMA and the Colonial Office’, *BMJ, Supplement*, 1926, pp.27–8; PRO/CO/533/662 ‘East Africa Medical Staff Regulations’, 1926–7; Although some MOs felt that the published warning changed things very little. Gilks, ‘The Medical Department and Health Organization’, p.351

²⁵⁰ RHL/MSS.Brit.Emp.s.415, Furse Papers, Memorandum: ‘On the Difficulty of Obtaining Candidates for the Colonial Medical Service’, p.1

reinforcing an impression that Colonial Service doctors were less competent than their contemporaries back home, or at least were part of an ill-fated organisation. It is ironic that, while the BMA's campaign lessened the appeal of the career to top medical graduates, the CO was more concerned with recruiting good character 'types' than top-notch candidates.²⁵¹

* * *

In describing sources of complaint and dissatisfaction is not intended to suggest that MOs were perpetually unhappy; on the contrary, most memoirs are coloured by genuine fondness and emotional attachment to African life. Even if some of the terms and conditions of employment were problematic, it was acknowledged that many aspects of the lifestyle were highly enjoyable and that the extraordinary experiences conferred rare and valuable opportunities upon colonial doctors. Even when discontentment with the service peaked in the 1920s, evidence suggests that, on the whole, MOs were not seriously unhappy.²⁵² Recruitment, although never totally adequate indicates that discontent was not a serious disincentive to new candidates. The exotic and adventurous images surrounding colonial life were pervasive enough to guarantee a certain amount of tolerance. It was expected that life would be testing; in fact it was a desire to escape the predictable ordinariness of the home medical profession that enticed many young candidates overseas.

The common motifs discussed in this section supplement the account provided within the earlier sections of official duties within the changing contexts of the Medical Department. For each instance that purports to sustain a particular conclusion, counter evidence can undoubtedly be found. All contribute to the fascinating kaleidoscopic picture of what being an MO actually meant in practice.

²⁵¹ Explored in section 2.3, pp.63–74

²⁵² The results of a questionnaire submitted to all members of the Kenya Medical Service "would seem to indicate that no serious dissatisfaction exists in the Kenya Service". 'British Medical Association', *KMJ*, 1, 1924–5, pp.54–5, p.55

4.4 Women in the Colonial Medical Service

An analysis of colonial medical experiences would be incomplete without specific reference to women MOs. Though they were subject to the same pressures and concerns as their male colleagues, their minority experience was necessarily different in some respects. Women were not officially excluded from employment within the Colonial Service (except some branches, such as the Administrative Service), but the traditional, masculine ethos of this government career made it a less appealing option for many female candidates. Not only would women have had to convince an all-male interview panel of their suitability, they had to contend with pervasive beliefs which strongly argued for the long term unsuitability of women for tropical residence.²⁵³ Furthermore, the African Medical Service, like the Administrative Service, was considered to require characteristics of leadership, resourcefulness, mental stability, and stamina that were mostly identified as masculine traits. Consequently, the few openings available to women within the Colonial Service by the 1920s were principally situated within the nursing or educational services. Very few Colonial Medical Service jobs were for female entrants. When medical jobs for women did come up, they were almost exclusively associated with education or maternity and child welfare work, a gendering of duties that was quite typical for women doctors at that time in Britain.²⁵⁴

In this context the experiences of the few women MOs during this period are even more remarkable. In Kenya, Uganda and Tanzania between 1893 and 1939 only twelve women (less than 3% of the total number of officers) worked for the Colonial Medical Service (Figure 4.1). Eleven of these were recruited in the 1920s and 1930s, representing roughly 15% of the total number of female MOs recruited to the Colonial Service during that time. When this is compared to the 2,189 women recruited in the same period for the Empire nursing services it can be seen how comparatively restricted female doctoring opportunities were. Although some places, for example, the Federated Malay Straits, seemed to be more open to

²⁵³ 'European Women and Children in the Tropics', *BMJ*, i, 1931, pp.268-9

²⁵⁴ Women's suitability for certain types of medical training above others is discussed in E Thomson, 'Physiology, Hygiene and the Entry of Women to the Medical Profession in Edinburgh, c.1869-c.1900', *SHPBBS*, 32, pp.105-126

recruiting female MOs than others, women made up only a very small percentage of the colonial medical cohort.²⁵⁵ Significantly no women held any medical department headships or deputy headships within the period in East Africa and no women obtained the rank of SMO. When women did do exceptionally well it was usually as researchers. No women took a leading rôle in other areas of colonial development, such as the development of medical education for Africans or the public health campaigns that occurred in the second half of the period. This is not a criticism of the part women played, but an acknowledgement that opportunities were few and when they did present themselves, were severely curtailed. Although the Assistant Medical Adviser to the CO, Archibald Smart stated in 1939 that he felt that there was “increasing scope” for women, even as comparatively late as 1949 another official commentator described the prospects for women in the Colonial Services as still being dominated by nursing, clerical and educational vacancies.²⁵⁶

Gender Distribution: Kenya, Uganda, Tanzania



²⁵⁵ For the comparatively large number of women MOs in The Federated Malay States see *The Colonial Medical Service List*, 1936

²⁵⁶ Smart, ‘An Impression of Life in the Colonial Medical Service’, p.124. Statistics produced for the CO showed that between 1922 and 1943 just 72 women in total were recruited for positions in the whole of the Medical Service. Jeffries, *Partners For Progress*, p.152

Figure 4.1: Gender Distribution in EAMS, 1893–1939

The low representation of women within the Colonial Medical Service directly reflected the small chances for women to enter medical school in the early part of the twentieth century. Although medical opportunities had grown since women first began to participate in university medical education in the 1860s and 1870s, it took the shortages of male doctors precipitated by the First World War to sustain women's entry into medicine with any force.²⁵⁷ Such positions as existed were available at home rather than in the far reaches of the Empire, and there was never an active recruitment drive to attract female medical graduates to the Service. When women doctors did choose colonial careers, they usually worked as missionaries, sometimes accompanying their missionary husbands.²⁵⁸

Although women were poorly represented, Uganda appeared to be the most open of the three territories to the recruitment of women. It was there that the first woman MO, Muriel Robertson, was appointed in 1911. It was an auspicious start, as Robertson became widely acknowledged as one of the most important protozoologists of her generation.²⁵⁹ Significantly, Robertson did not enter the Colonial Medical Service through the usual CO interview route, but joined after having been as part of the Royal Society's Sleeping Sickness Commission in Uganda. Her period in the Colonial Service lasted only three years, during which time she produced "a number of scientific papers completely elucidating...the development of the causative organism (*Trypanosoma*) in its transmitting insect, [the] tsetse fly"; work which was described in 1973, as having "never been superseded" and which "contributed enormously" to the subsequent understanding and elucidation of the disease.²⁶⁰ Robertson returned to the United Kingdom after the outbreak of the First World War but continued her research on parasitic protozoa, eventually becoming

²⁵⁷ C Blake, *The Charge of the Parasols: Women's Entry to the Medical Profession*, 1990, p.168 See also TN Bonner, *To the Ends of the Earth: Women's Search for Education in Medicine*, Cambridge, MA, 1992

²⁵⁸ The earliest reference I have found to a woman doctor in East Africa was a missionary in Kenya in 1897. 'EM Hooper', *The Medical Directory for 1897*, Vol. 2, 1898, p.1647

²⁵⁹ 'Muriel Robertson' *Who Was Who, 1971–1980*, Volume VII, 1981, p.676; 'Muriel Robertson', *The Times*, 22/06/1973, p.18

²⁶⁰ *Ibid.*

head of the Department of Protozoology at the Lister Institute (1944), and being elected FRS in 1947.²⁶¹

At least two other women were thought worthy of obituaries: Mary Michael-Shaw, who was a specialist in venereal diseases in women and children, and Mary Turton who had a long and successful career in bacteriology in Uganda before returning to England just before the Second World War.²⁶² Turton achieved the rank of Senior Pathologist (previously titled Senior Bacteriologist), the highest rank a woman reached in the pre-World War Two East Africa Medical Service. Notably, it was also a woman, Margaret Holliday, who held the first specialist surgical posting made to Mulago Hospital, Uganda in 1926.²⁶³ Predictably, Holliday was appointed expressly to deal with female and infant surgery, in keeping with the conventional remit of women doctors.

Little other evidence of the other women MOs survives. An examination of job titles and other chance mentions within the sources, confirms that most had obstetrical, gynaecological and paediatric duties.²⁶⁴ By the 1930s exclusion from other medical areas was the cause of some frustration among the female profession and some complaints explicitly addressed this gender-orientated categorisation of duties.²⁶⁵ Women were occasionally active protestors. An early medical history of Uganda by Albert Cook, recalled how an unnamed woman MO brought a “bitter indictment” against Mulago medical school for their policy of compulsorily examining women suspected of having venereal disease.²⁶⁶ Although Cook does not name the MO involved, it was probably Margaret Lamont, who was an employee of the Uganda service in Mulago at that time. As was typical of those who voiced their complaints

²⁶¹ ‘Muriel Robertson’, Royal Society, *Biographical Memoirs of Fellows of the Royal Society*, Vol. 20, 1974, pp.217-47

²⁶² ‘Mary Michael-Shaw’, *BMJ*, ii, 1963, p.1343; ‘Mary Turton’, *BMJ*, ii, 1958, p.1048

²⁶³ Boase, ‘Reminiscences of Surgery’, p.199

²⁶⁴ For a description of Cicely Twining’s duties KNA/MOH/3/246 F Johnstone (for DDMS), Circular Despatch: 20/12/1920

²⁶⁵ PRO/CO/850/14/20 ‘Women Medical Officers’, 1932; PRO/CO/850/33/28 ‘Women Medical Officers’, 1933

²⁶⁶ AR Cook, ‘The Medical History of Uganda: Part 2’, *EAMJ*, 13, 1936–7, pp.99–110, p.100. This practice (codified by the Contagious Diseases Acts in nineteenth-century England) was much criticised. See J Walkowitz, *Prostitution and Victorian Society: Women, Class and the State*, Cambridge 1980; P Levine, *Prostitution, Race and Politics: Policing Venereal Disease in the British Empire*, 2003

too vehemently, Lamont left the Service after her protests — those who did not fit to the prevailing ethos were not easily assimilated.

Despite these anomalous examples the CO itself had remarkable little to say on the woman question. There was very little coordinated action during this period, either from within or without the Service, to improve opportunities for women within the medical corps. When issues did arise they were usually dealt with on a case-by-case basis: such as the protest made by Cecily Twining that she had to resign her position of MO upon marriage.²⁶⁷ By the 1930s queries was also made (by the National Council of Women of Great Britain) as to why there were no women representatives on the Colonial Appointments Board.²⁶⁸

Only one first-hand account from a woman MO survives. That of Peg [Margaret] Wilson. Wilson was not officially appointed a full-time MO until 1948, but she had informally worked with her husband in Africa since the 1920s.²⁶⁹ Apart from the fact that she was eventually officially employed by the Colonial Medical Service, Wilson's situation was not atypical; colonial wives, a number of whom were medically qualified themselves, played a large rôle in colonial communities.

The number of MOs stationed in East Africa who were married to doctors is difficult to quantify, as colonial records do not record the qualifications of spouses. Some medical wives, perhaps finding it difficult to get work with the Colonial Medical Service, registered independently as private practitioners. The Kenya and Tanzania *Government Gazettes* of the period are an informative guide as they regularly published the names of all licensed practitioners resident within their respective countries, with the type of medical practice in which each individual was engaged (private, missionary, government etc.).²⁷⁰ Many private practitioners listed were women, who shared the surname (and often the same medical school) of men in government service at the time. Examples include, Shona Aitken (wife of William

²⁶⁷ PRO/CO/381/9 'Kenya: Ladies on Permanent and Pensionable Establishment., Question of Resignation in Event of Marriage', 1928–29

²⁶⁸ PRO/CO/850/14/2 'Employment of Women in the Colonial Services', 1932

²⁶⁹ RHL/MSS.Afr.s.1872/162(a) Wilson, 'Memoirs of Service'

²⁷⁰ Although UP Gov.Gaz. did publish the names of all licensed practitioners in the country, it did not specify in what capacity each individual worked.

Aitken, Tanzania); Violet Clarke (wife of James Clarke, Kenya); Gwendolen Chataway (wife of James Chataway, Kenya); Maud McNaughton (wife of James McNaughton, Tanzania); Jane Vint (wife of Francis Vint, Kenya); Frances Wilcocks (wife of Charles Wilcocks, Tanzania).

Some of these medically qualified women became informally involved in local healthcare schemes. Charles Wilcock's wife, Frances, for example, seemed to have been regularly occupied with her husband's district based work,²⁷¹ and Peg Wilson had worked informally or on short-term contracts for the Colonial Service since her arrival to join her Colonial Medical Service employed husband Bagster Wilson.²⁷² Within months of her arrival in 1930, Peg Wilson, who had worked as a doctor in Nepal, was examining blood specimens in the makeshift laboratory in Tabora and in the following years routinely accompanied her husband on medical safaris, conducting inoculations and health examinations. She was so helpful that her husband claimed that when she was ill, his laboratory work doubled. During periods when the annual report was being prepared Wilson described her life as "entirely coloured" by it and she certainly played an active rôle in its production. By 1933 Wilson was working formally as a part-time entomologist,²⁷³ and in 1939 she took up a position as a Health Officer, finally being appointed a full MO in 1948. She became an accomplished parasitologist and entomologist, and remained working in Uganda until 1965, when she moved to the Medical Research Council's unit in the Gambia. She stayed there until 1973 and eventually retired at seventy-six years of age.²⁷⁴

Not all careers were as dynamic as Peg Wilson's. Some colonial wives found colonial life tiresome and insalubrious, others played a very active part in the districts. Hugh Trowell recalled how his wife, Peggy, accompanied him on some of his medical safaris, and although she did not feel comfortable with medical matters, helped by illustrating some of the public health information booklets issued in Kenya

²⁷¹ RHL/MSS.Afr.s.796, C Wilcocks, Diary, 1928-9, 13/09/1928

²⁷² RHL/MSS.Afr.s.1872/162 (a), M Wilson to A Smith, ORDP, 13/02/1983

²⁷³ Tanganyika Territory, *An.Med.Rep.*, 1932, Dar Es Salaam, 1933, p.22

²⁷⁴ RHL/MSS.Afr.s.1872/162(a) Wilson, 'Memoirs of Service'

for distribution to African families.²⁷⁵ Farnworth Anderson, too, remembered how his wife was a regular companion on the medical safari trail.²⁷⁶ Robert Moffat's wife, Hilda, was "dragged in" to assist him with his duties, because he found himself too busy to undertake all the paperwork on his own. He was happy to report that she "really makes a very good amanuensis".²⁷⁷ Robert Procter's wife was also active in district medical care and was, along with the Assistant District Commissioner wife, "recruited to vaccinate" the native inhabitants of Fort Hall, Kenya against smallpox in the early 1920s.²⁷⁸

The rôle of Colonial wives, although not entirely unappreciated, largely remains unexplored within Colonial Service history.²⁷⁹ Just as men needed to be the right "sort of chap", the wives that accompanied them needed to be of the right stamp if they were to endure, and even thrive, among the stresses integral to colonial life. One official wrote how fortuitous it was that the selection procedure, with its reliance on character and interview, was also a means whereby the right sort of wives were also indirectly chosen: "[p]rovidence no doubt arranges that the sort of chap who is the sort of chap they want in the Colonial Service chooses (or is chosen by) the sort of wife he ought to have".²⁸⁰ The best sort of woman was described as "one of the modern out-of-door practical girls that are fortunately becoming so common".²⁸¹

Some husbands clearly worried about the suitability of African life for their wives; one MO considered that they "had a lot to put up with".²⁸² Life for wives was

²⁷⁵ RHL/MSS.Afr.s.1872/144b Trowell, tape 1B, p.7; WL/CMAC/PP/HCT/A5 Bray, *Hugh Trowell: Pioneer Nutritionist*, [Chapter 5] p.7

²⁷⁶ RHL/MSS.Afr.s.1653, Anderson, *Reminiscences*, Book I, p.24

²⁷⁷ Quotation from the Moffat Letters, Makerere University Library [no further reference], quoted in W.D. Foster, 'Robert Moffat and the Beginnings of Government Medical Service', p.246

²⁷⁸ RHL/MSS.Afr.s.702, Procter, 'Random Reminiscences', p.4

²⁷⁹ But see Jeffries, *Partners For Progress*, pp.155–8; 'From the Woman's Viewpoint' in A Kirk-Greene, *Glimpses of Empire: A Corona Anthology*, 2001, pp.228–77

²⁸⁰ Jeffries, *Partners For Progress*, p.156

²⁸¹ Lady Cranworth, 'Hints for a Woman in British East Africa' in Lord Cranworth, *A Colony in the Making. Or Sport and Profit in British East Africa*, 1912, pp.84–92, p.92

²⁸² RHL/MSS.Afr.s.1653, Anderson, *Reminiscences*, Book I, p.28. The motif that Africa was a rather dull place for wives was frequently articulated at the time, see M Trowell, *African Tapestry*, 1957, p.15; For a description of the three 'Ds' (Danger, Discomfort and Dullness) that potentially affected wives see Lady Cranworth, 'Hints for a Woman in British East Africa' p.84

not easy, with their husbands having more social stimulation and the benefit of professional interaction. Connell commented that, while he was very busy with his duties, he could appreciate that “[i]t is pretty deadly for a woman”.²⁸³ Nevertheless, most wives seem to have had an important part to play in colonial life; even those women who had no interest in pursuing matters medical, often created niches for themselves in society by getting involved with local community projects or educational initiatives.²⁸⁴

Women were not readily recruited into the Colonial Medical Service before 1945,²⁸⁵ but the prospects for women gradually began to improve from the 1930s. However, there is little evidence to suggest that they were regularly turned down for positions or that they participated in high-profile campaigns to increase their opportunities in this sector. Those women who did actually choose the career should be credited with having combated two formidable hurdles: overcoming widespread restrictions over women’s entry into medical education; and overriding assumptions that women had no serious contribution to make within the government services other than in the nursing, clerical or education services. As will be discussed in the next chapter, women also had an important social part to play in colonial life. Their presence helped to normalise the otherwise exotic or exceptional experiences of colonial life, contributing to the creation of communities that made life feel, in some important ways like a home-from-home.

* * *

Medical practice in the Colonial Medical Service in Kenya, Uganda and Tanzania shared a number of similarities. First, the broad classification of jobs and duties into four main tiers of responsibility (PMO, DPMO, SMO and MO) were identical and each of the Medical Departments were organised to the same fundamental standards

²⁸³ RHL/MSS.Afr.s.708 (1), WK Connell, Diary 1924–5, 21/10/1924, p.24

²⁸⁴ For an impressive example of this see the biography of Margaret Trowell, wife of Hugh Trowell and later Head of the School of Art, Makerere College, Uganda. Trowell, *African Tapestry*

²⁸⁵ After World War Two campaigns began to be directed at including more women in the Colonial Service. See Colonial Office, *Colonial Service Recruitment No. 9: Information Regarding Appointments for Women*, 1945, extract reproduced in A Kirk-Greene, *On Crown Service: A History of HM Colonial and Overseas Civil Services, 1837–1997*, 1999, pp.196–8

that followed the precedent established by the WAMS and, before that, the IMS. Although some bureaucratic structures took time to be established, once they were, the overriding aim (even before Medical Service unification in 1934), was to create medical services within all British dependencies managed along roughly the same lines. Attempts were persistently made to coordinate practices between the three territories and to institute common procedures and policies. Moreover, the ways in which the medical rôles developed and expanded within the changing contexts of colonial medicine also loosely followed a reciprocal pattern. After 1919, colonial medical policy was extended and was intentionally orientated towards public health matters, administrative decentralisation, research and specialisation, and the training of Africans as auxiliary healthcare workers. Towards the end of the period, regional medical conferences occurred with increasing frequency between Kenya Uganda and Tanzania, emphasising that the three otherwise distinct countries were moving toward broadly similar medical goals.²⁸⁶

As all officers were part of both these shared administrative structures and communal policies, it is not surprising that MOs perceived and experienced colonial life in a broadly similar way. While individual opinions and perceptions varied, and clear regional differences existed, an ethos emerged that eclipsed the idiosyncratic differences. All MOs were part of the same Service; their professional training, place and employer unified them. All had to work daily within the same hierarchy, they had to follow the same briefs, obey the same regulations and adapt to their departmental decisions over the focus of medicine. This fostered a sense of solidarity, which was enhanced (further than other shared professional identities back home) through the colonial context. Here MOs were not only united through their profession and shared experiences, but also unified by their skin colour and their status as part of the ruling elite. This forged bonds, which went over and above any rivalries that developed. It also created and perpetuated, as will be argued in the next chapter, a specifically colonial medical identity.

²⁸⁶ Regional conferences on the coordination of medical research took place in 1933 and 1936

5. Colonial Medical Identities

In lonely stations, far from the restraints of European public opinion and supported by no lavish remuneration, the officer must remain dignified and incorruptible. Moreover, with whatever margin of individual qualities, the members of this increasing corps must share the same standard of conduct and manners sufficiently to allow them to understand one another. They must act, when dispersed over wide and tested regions, upon similar principles and in pursuit of the same almost unspoken purposes.¹

A substantial body of historical work has examined from different angles the creation of imperial ruling class and imperial subjects.² The question of a specifically colonial medical identity, however, has only recently become the subject of historical scrutiny in its own right.³ There has been relatively little concentration on the actual *constitution* of colonial group identities, or what they could mean for, or add to, broader medical historical accounts.⁴ This is despite the fact that medical historians have regularly, usually implicitly, assumed the importance of common group markers as a means of moulding and perpetuating collective experiences and expectations. This chapter offers an expansive, culturally embedded, description of colonial communities within medical history, based on empirical evidence. The aim is to draw upon and augment the historiographical debates over colonial identity presented in the first chapter (see, pp.34–41) and to explore the way that certain common themes were manifest in the attitudes and behaviours of colonial doctors. The stereotype of the colonial medical servant is explored and compared to a detailed analysis of ‘real’ colonial medical profiles (Sections 5.1; 5.2). Unifying features that contribute to the formation of a specifically colonial medical identity in East Africa are then examined in Section 5.3.

¹ M Perham, ‘Introduction’, in R Heussler, *Yesterday’s Rulers: The Making of the British Colonial Service*, New York, 1963, p.xx

² Some of the most famous examples: EW Said, *Orientalism: Western Conceptions of the Orient*, Harmondsworth, 1995 [1978]; E Hobsbawm and T Ranger (eds.), *The Invention of Tradition*, Cambridge 2002 [1983]; D Cannadine, *Ornamentalism: How the British Saw Their Empire*, Harmondsworth, 2001

³ MP Sutphen and B Andrews (eds.), *Medicine and the Colonial Identity*, 2003

⁴ Some important exceptions include work that has been undertaken on the creation of colonial medical subjects. M Vaughan, *Curing Their Ills: Colonial Power and African Illness*, Padstow, 1991; W Anderson, *The Cultivation of Whiteness: Science, Health and Racial Destiny in Australia*, New York, 2003

This chapter argues that a tacit sense of kinship between Colonial MOs was informed by a desire to present a united front. This desire fostered and encouraged group loyalty, stifled dissenting voices and created in the colonial setting an environment that was based on traditional notions of Britishness but was also adapted to be uniquely British-East African. Furthermore, the distinctiveness of this cadre was particularly intense, as it was drawn from several sources each with strong and established identities. Members of the Colonial Medical Service were not only members of the white ruling class minority, they were British citizens, and mostly male. Moreover, their identity was overlaid by employment by a single agency (the Colonial Medical Service) and membership of a distinct profession (medicine), with closely converging tropical medical interests. The colonial medical identity, it is argued, transcended the individuality of those who made up the group.

5.1 The Colonial Service Stereotype

Strong correlations exist between Colonial Service stereotypes and the actual prosopographical make-up of the medical cohort, but the composition of the Medical Service diverged in several important ways from the conventional image of colonial officers during this period. Three important aspects stand out as being fundamental to generalised public perceptions of Colonial Service identity: first, the image that the Service was principally made up of upper-class, or at least upper-middle class, entrants who had attended either Oxford or Cambridge Universities.⁵ Second, the idea that the group advocated predominately traditional values based on public school notions of sportsmanship, fair-play, and conservatism — with an over-riding respect for time-honoured practices and a general resistance to innovation or change. Third that Colonial Officers were somehow intrinsically a more adventurous, heroic type, guided in their career choice through an innate spirit of adventure, which differentiated them from their contemporaries at home.

⁵ Attendance at Oxbridge, did not necessarily mean that the stereotypical Colonial Officer was academically exceptional. In fact, the more common tendency amongst Colonial Officers was that they were good sporting, practical types more than intellectuals: "They have a practical rather than a theoretical bent, and are vastly more interested in a concrete problem...than in speculations on, for example, the ultimate goal of Empire". LA Mills, 'Methods of Appointment and Training in the British and Dutch Colonial Civil Service', *APSR*, 33, 1939, pp.465–72, p.472

These images partly derived from the character of British officialdom in India, which had a more established tradition of overseas public service than the African Colonial Service. The renowned severity of the entrance examination to the ICS meant that recruits were generally drawn from a privileged social group with access to a classical education.⁶ ICS entrants had typically attended public school and then Oxford University, which remained, above Cambridge, the most popular university for fledgling ICS officials until 1939.⁷ This image of privilege surrounded high profile ex-colonial officers such as Leonard Woolf and George Orwell. These links fuelled accepted assumptions that Colonial Officers tended to comprise a prosperous, public (i.e. private) school educated social elite.⁸

This dominant impression of entrants is sustained by studies that have profiled members of the various Empire political services. Important works undertaken by Henrika Kuklick about members of the Gold Coast Administrative Service, or Alex McKay with regard to the political cadre stationed in Tibet (who were drawn from the colonial government of India) have confirmed that the colonial type was, by and large, taken from a public school, Oxbridge-educated pool. These individuals were frequently the sons of landed or professional parents and, naturally enough, sported many of their ideological trappings.⁹ Data collected by Bruce Berman on the Kenyan Colonial Service between 1919 and 1939 similarly shows that 90% of those officials for whom he could find information were British public school graduates, three quarters of whom had attended Oxford or Cambridge Universities.¹⁰

⁶ P Woodruff, *The Men Who Ruled India: the Guardians* Vol.2, 1963 [1953], pp.75–9

⁷ DC Potter, *India's Political Administrators 1919–83: From ICS to IAS*, Delhi, 1996 [1986] p.71 quoted in P Marshall, 'The British Experience of Imperial Rule' in J Smith (ed.), *Administering Empire: The British Colonial Service in Retrospect*, 1999, pp.1–18, p.5

⁸ D Hammond and A Jablow, *The Africa That Never Was: Four Centuries of British Writing About Africa*, New York, 1970, p.183

⁹ H Kuklick, *The Imperial Bureaucrat: The Colonial Administrative Service in the Gold Coast, 1920–1939*, Stanford, CA, 1979, p.27; A McKay, *Tibet and the British Raj: The Frontier Cadre, 1904–1947*, Surrey, 1997, pp.77–80

¹⁰ B Berman, *Administration and Politics in Colonial Kenya*, Unpublished PhD, Yale University, 1973, p.95, p.97 cited in D Kennedy, *Islands of White: Settler Society and Culture in Kenya and Southern Rhodesia, 1890–1939*, Durham, NC, 1987, p.73

Works by Kirk-Greene and Crawford also support these specific studies through their broad historical analyses of different spheres of colonial recruitment.¹¹

The profile of colonial recruits naturally reflected the policies pursued by Ralph Furse at the CO, and others in equivalent positions in the Foreign Office or India Office.¹² Furse quite consciously favoured a certain type of recruit (see Chapter 2) and the subjective ideas about character that came into play during the recruitment process, as well as the continuation of many of the tenets of patronage, influenced the class group that was actively recruited. Not only were those who came from good colonial families deemed particularly suitable types, but since full university scholarships were rare before the Second World War, the reliance on Oxbridge as the main recruitment base ensured that candidates were of relatively uniform class origins. The families from which graduates were drawn necessarily had to have a certain amount of disposable income to afford university education for their sons. Despite these official preoccupations with class and gentility, a noteworthy proportion of Colonial MOs came from a broader social and educational background.

The face of the Colonial Service was unfailingly traditional and conservative in outlook. Even if the class origins of the individual members did not always fit with the ideal — as increasingly occurred from the 1930s and 1940s — the traditional ruling class ethos that typified the Colonial Service offered tangible opportunities for the socially ambitious to improve their status.¹³ As Kirk-Greene argued in his study of Colonial Service novels, even if the protagonists were from unexceptional middle class backgrounds “their ‘ordinary’ personality became magnified and their emotions heightened by the very un-suburban way of life” the career gave them.¹⁴ The

¹¹ A Kirk-Greene, *On Crown Service: A History of HM Colonial and Overseas Civil Services, 1837–1997*, 1999, p.94; DG Crawford, *Roll of the Indian Medical Service, 1615–1930*, 1930, pp.636–55

¹² This is not to say that ‘younger’ universities did not complain about discrimination PRO/CO/877/4/19 HJ Fleure, University College of Wales, Aberystwyth to Ormsby-Gore, 26/11/1927; Cambridge also complained that Oxford was getting “too large a share in ruling”. A Cambridge representative, Mr Guy, told Furse “Africa should be saved by having in the service a strong element of hard-headed Cambridge graduates”. PRO/CO/877/10/2 Minute: Furse, 19/01/1933

¹³ eg, Lord Twining, Governor of Tanzania. D Bates, *A Gust of Plumes: A Biography of Lord Twining of Godalming and Tanganyika*, 1972, pp.102–5

¹⁴ A Kirk-Greene, ‘The Colonial Service in the Novel’ in Smith (ed.), *Administering Empire*, pp.19–45, p.41

Colonial Service, in reality and fiction, took individuals to places that represented excitement and difference, and increased their professional prestige.¹⁵ Membership of this group also automatically and implicitly enrolled individuals as supporters of its core values, which stemmed from the key public school tradition of *noblesse oblige*. This assumed the right to rule through such traits as heroism, discipline, leadership, self-control, courage, sport, fair-play and a respect for tradition. It was world-view that was politically conservative, any more radical elements within it being silenced for the sake of preserving the status quo.¹⁶ These traditional values were, moreover, associated with certain physical attributes. The successful officer would be a sporting, outdoor type physically able to endure (even relish) the climate and the strenuous life that the colonies presented.¹⁷

While the image of the physically strong and morally upstanding hero had much of its basis in the public school tradition (see Chapter 3), many of these class associations in the colonial context were reinforced by ideas of heroism and exoticism found in popular stories of exploration.¹⁸ British popular culture was packed with images directly linking colonialism with adventure and some of these, naturally enough, affected perceptions of Colonial Service officers. Following the big-selling nineteenth-century biographical accounts of Victorian explorers such as Stanley, Livingstone, and Kingsley, a new trend in fictional writing about similar topics took off from the second half of the nineteenth century onwards. Writers such as George Alfred Henty (1832–1902), Rider Haggard (1856–1925), and Edgar Wallace (1875–1932) achieved great popular appeal, as did the influential stories that featured in popular comics of the day, such as *Boy's Own Paper* (launched 1879), or in the Edwardian period *The Magnet* and *The Gem*.¹⁹ Additional to this was the influence of

¹⁵ Cannadine, *Ornamentalism*, pp. 128–30

¹⁶ Harrison has argued that the IMS was an essentially conservative group, the ruling classes having become more cautious in their policies since the unrest caused by the mutiny of 1857. M Harrison, *Public Health in British India: Anglo-Indian Preventative Medicine 1859–1914*, Cambridge, 1994, p.5. It should also be noted, however, that some eccentricity was permitted.

¹⁷ JA Mangan, *The Games Ethic and Imperialism: Aspects of the Diffusion of an Ideal*, 1998 [1986]

¹⁸ F Driver, *Geography Militant: Cultures of Exploration and Empire*, Oxford, 2001

¹⁹ PA Dunae, 'New Grub Street for Boys', in J Richards (ed.), *Imperialism and Juvenile Literature*, Manchester, 1989, pp.12–33; Edgar Wallace's immensely popular *Sanders of the River* books were said to have been "immediately and unambiguously recognisable in Britain's popular culture as a symbol for the colonial administrator". Kirk-Greene, 'The Colonial Service in the Novel', p.19

film. By the 1930s, Empire films began to be produced in Britain and America with telling regularity. Pictures such as *Sanders of the River* (1935); *Rhodes of Africa* (1936); *King Solomon's Mines* (1937); *Four Feathers* (1939); *Stanley and Livingstone* (1939) provided forums for escapism (especially from the Depression) and helped to further entrench stereotypical ideas about colonials.²⁰ Of course more than one colonial type was caricatured in film and popular literature: for every upper-class dynamic hero there was a bumbling buffoon to counterbalance him, and for every ambitious young careerist a dreary misanthropic counterpart immersed in the intricacies of bureaucracy. However, the image of the colonial officer, explorer and missionary as a privileged, healthy and adventurous chap was omnipresent.²¹ The stereotype was, moreover, usually derived from collective ideas surrounding the CAS, which as the biggest branch of the Colonial Service dominated all other impressions of colonial types.²²

With regard to British East Africa, it is important to acknowledge that many of the archetypal images derive specifically from Kenya. The colony contributed disproportionately to perceptions of colonial life owing to its prominent public profile, directly derived from the large and vocal British settler population. Many quixotic ideas became specifically associated with Kenya owing to its healthy climate, dramatic rolling hills, opportunities for big game hunting and relatively close historical connection with the lives of African explorers such as Livingstone, Stanley and Kirk. These romantic links were important because of the public (and often salacious) rumours surrounding the 'happy valley' that dominated much of the gossip emanating from the country between the 1920s and 1940s. Although these reports were principally about the settler, rather than the official, community, they nevertheless fired popular perceptions of East African life in much more general

²⁰ K Dunn, 'Lights...Camera...Africa: Images of Africa and Africans in Western Popular Films of the 1930s', *ASR*, 39, 1996, pp. 149–75

²¹ Vaughan, *Curing Their Ills*, pp.155–79

²² Indicative profiles of Administrative Officers can be seen in a series of tables compiled by the CO. Oxford and Cambridge predominate as the favoured recruitment sources and the 4 most frequent places CAS Officers were schooled were Marlborough, Wellington College, Charterhouse and Winchester. PRO/CO/877/16/21 'Colonial Administrative Service: Universities of Successful Candidates 1931–1941 inclusive' and 'Colonial Administrative Service: Schools of Successful Candidates for the Years 1931–1941 inclusive' [n.d. c.1942]

terms. Images of Kenya during this period frequently depicted colonials *en masse* as part of a gay, decadent community, preoccupied with dinner parties, hunting safaris, champagne breakfasts and sexual excesses. Most importantly, this colonial set were all thought to be having a thoroughly good time, markedly different from their contemporaries in industrial, Depression-ridden, Britain.

This image, which Evelyn Waugh famously described as the colonial life of the “English Squirearchy”, contained some truth. Kenya was, after all, home to many members of the British ruling classes, such as Lord Delamere, Lord Cranworth and Lord Erroll, and no doubt this society did affect the behaviour and expectations of other British groups resident in Kenya. Other colonies had a different social structure and distinctive preoccupations arising from their particular circumstances,²³ but the associations that surrounded Kenya were especially powerful in moulding ideas about colonial East African life.

The stereotype of the Colonial Officer was an amalgamation of numerous ideals of Britishness but, crucially, it was also, differentiated from home society through its celebration of specifically local African influences. Colonial MOs both conformed to, and diverged from, the images of Colonial Service types. In some ways they drew upon and perpetuated popular images, but in other important ways they distanced themselves from them — not least because of their professional associations, which demarcated them as doctors whose immediate aims were humanitarian, rather than political who ruled. Even if their collective behaviour upheld many distinctive colonial attitudes, this group, nevertheless, had a subtly distinct identity of their own.

5.2 The Colonial Medical Service: The Prosopographical Results

In total 424 MOs served in the Colonial Medical Service of British-ruled Kenya, Uganda and Tanzania before World War Two. In some cases the information obtained for this group has been consistently available, in others it has disappeared. It is particularly regrettable that the original CO P1 (Med.) application forms —

²³ E Waugh, *Remote People*, 1931, pp.182–3; E Huxley, *White Man's Country: Lord Delamere and the Making of Kenya* (2 Vols.), 1953 [1935], pp.248–57

except for a handful which have turned up in archives where they officially should not have been — were all destroyed after a fixed period of time through a centralised policy of the CO.²⁴ These documents would have been exceptionally useful, especially if (as in the case of the IMS) they had been accompanied by copies of each applicant's birth certificate.²⁵ Access to this information would have allowed the inclusion of standard biographical information pertaining to fathers' professions (and therefore class) and would have given dates, places of birth and details of schooling for each individual. Nevertheless, data for each MO has been cross-referenced from a variety of sources.²⁶

Class profile

Doctors were drawn from a more diverse social group, than, for example, colonial administrators, and they did not necessarily comply with the dominant stereotype of the financially privileged Colonial Service official. A number of MOs mentioned in their memoirs that they came from less well-off family backgrounds; indeed, it seems that the promise of a regular salary and additional allowances actually stimulated some doctors' to choose a colonial career (see Chapter 3). Occasionally the socially privileged joined the Colonial Medical Service (for example, Drs Fairfax Bell, Arthur Bagshawe and Clinton Manson-Bahr), but their presence did not dominate the East African cadre.²⁷

The mixed class background of the Medical Service compared to the Administrative Services is echoed in the work of Mark Harrison who has shown that, between 1859 and 1914, IMS recruits were drawn from a broader social grouping than their equivalents in the ICS. Interestingly, Harrison also found that the IMS

²⁴ A Kirk-Greene, 'Colonial Service Biographical Data: the Published Sources', *AR&D*, 46, 1988, pp.2–16, p.2; A handful of complete personnel files were found in the KNA, usually those of officers who were being considered for transfer or retrenchment.

²⁵ Harrison was able to cite these in his analysis of IMS recruits. Harrison, *Public Health in British India*, p.29

²⁶ For a description of the methods (and criteria) used to construct this dataset see Appendix 1

²⁷ One way of ascertaining social privilege is through analysing schooling. Information of this nature has been found for 125 (roughly a third) of MOs. The data is too crude and patchy to be of much use (it is impossible to know who were scholarship students), but schools mentioned that indicate a high social rank include, Lancing College, Marlborough College, Rugby School, Winchester College, St Paul's School and Robert Gordon's College, Aberdeen

doctors came from a less socially elevated background than their medical contemporaries practising in the UK.²⁸ This accords with the idea that entrance to the Indian and African Medical Services was seen as a means of enhancing social position.²⁹

Unsurprisingly, these broad-based class affiliations affected doctors' common perspectives and group identity. Doctors' positions in colonial society were determined not so much by class, as by collective membership of a special status group. Although MOs were an integral part of the colonial ruling classes, they regarded themselves — and their contemporaries in other branches of the Service — as an essentially different group. Very definite divisions formed within colonial society. Officials grouped together with like-minded colleagues, usually in the same branches of the Service as themselves.³⁰ Doctors were particularly defined through the occupation of medicine, which intimately associated them with a scholarly and scientific profession, rather than a political position with its associated ruling class pageantry and regalia.³¹ In some cases these differences were so pronounced as to present an “ostensive class barrier between the different types of colonial officer”, one that was said to have “fostered mutual hostility” between different Colonial Service groups.³²

Nationality

Without birth certificates nationality is difficult to establish. *Medical Directory* and *Colonial Office List* entries list, nearly always state the place from where individuals gained their medical education, but this cannot be used as definitive indicator of nationality, especially as it was fairly common for people to travel to prestigious medical schools. The CO regulations required all entrants to the Medical Service to be naturalised British citizens, although not necessarily born in Britain; after 1925, it

²⁸ Harrison, *Public Health in British India*, p.29

²⁹ Marshall, 'The British Experience of Imperial Rule' p.10

³⁰ Huxley, *White Man's Country*, p.185

³¹ Eg, doctors did not have to wear a uniform (apart from the most senior ranks at public events), whereas all Political Officers in Kenya Service were issued a khaki uniform. My thanks to Tony Kirk-Greene for supplying me with this information.

³² Kuklick, *The Imperial Bureaucrat*, p.150

was stipulated that both parents must be European.³³ Confirmation of national origins remains elusive and for some is available only from autobiographical writings or obituaries.³⁴

Scotland and Ireland were particularly well represented among the colonial medical profession.³⁵ As many of the MOs formally identified as Scottish went to Scottish universities, and Irish to Irish ones, it seems likely that educational background gives an indication of nationality (see Appendix 5). Although the lack of data precludes a formal count of national origins, it is estimated that around a third of all Colonial MOs were Scots and a sixth were Irish (Figure 5.1).

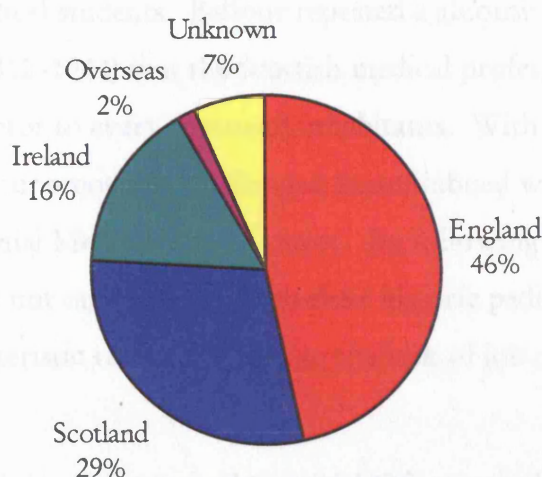


Figure 5.1: National Distribution of MOs' Qualifications

The large proportion of particularly Scots in the Medical Service can be related to their lack of access to the pre-requisite capital, or opportunity, to establish themselves as private practitioners in their home country from the 1880s onwards (Chapter 3, p.93).³⁶ Furthermore, the prominent colonial presence of Scots was

³³ *African (East) No.1105: Information for the Use of Candidates to Appointments in the East African Medical Service*, 1925, p.8

³⁴ And even then, nationality was not always stated.

³⁵ "The preponderance of Scotsmen is certainly remarkable". AR Cook, 'The Medical History of Uganda: Part 1', *EAMJ*, 13, 1936-7, pp.66-81, p.73; the Irish contingent has been less commented upon, but is noteworthy.

³⁶ MW Dupree, MA Crowther, 'A Profile of the Medical Profession in Scotland in the Early Twentieth Century: The Medical Directory as a Historical Source', *BHM*, 65, 1991, pp.209-33, p.222

based on a long established tradition of Scots overseas since the seventeenth century.³⁷ The large Scottish component of Empire meant that Scots would have been more exposed to the career through the accounts of colonial friends or relatives.³⁸ Other assessments have been based on more subjective ideas of Scottishness: Derek Dow has suggested that career choices favouring Africa were made by Scots as a means of satisfying a national desire to take on new challenging environments.³⁹ This idea is given added weight by the popular links between Scots and colonial adventure, as personified by David Livingstone and John Kirk.

Andrew Balfour called upon the combined factors of tough competition at home and an inherent tradition towards adventure in his 1924 colonial recruitment address to Glasgow medical students. Balfour repeated a gloomy forecast made by Sir Humphry Rolleston (1862–1944) that the Scottish medical profession would soon possess a glut of one doctor to every thousand inhabitants. With those sort of prospects at home, Balfour emotively challenged those imbued with the “blood of the Celt” to take up a Colonial Medical Service career. By following a Scottish tradition of *wanderlust* they were not only being true to their historic pedigree, but were responding with characteristic resourcefulness to the lack of job opportunities at home.⁴⁰

Although British extraction united Colonial Officers, it should be remembered that, within the overall articulation of British identity, there were definite sub-groups, which strongly identified with their Irish or Scottish ancestry (e.g. the Highland dancing societies in East Africa).⁴¹ As Julian Huxley remarked on his tour of British African colonies in 1929: “the Scots section of every colony is always large and always vocal”.⁴²

³⁷ TM Levine, *Scotland's Empire, 1600–1815*, 2003; see also M Fry, *The Scottish Empire*, Edinburgh, 2001

³⁸ Harrison has also argued that a strong Celtic fringe made up the IMS. Harrison, *Public Health in British India*, p.30–1

³⁹ DA Dow, ‘Some Late Nineteenth-Century Scottish Travellers in Africa’, *Pr.RSEd.*, 1982, 82A, pp.7–15

⁴⁰ A Balfour, ‘Vistas and Visions: Some Aspects of the Colonial Medical Services’, *GMJ*, 6, 1924, pp.353–74, p.354

⁴¹ RHL/MSS.Afr.s.1872/82 JK Hunter, ‘Detailed Memorandum on Experiences in the Colonial Medical Service in Uganda, 1939–58’, [n.d. c. 1983], p.22

⁴² J Huxley, *Africa View*, 1936 [1931], p.152

Education and Qualifications

In total, qualification information has been ascertained for 414 of the 424 MOs who make up this study (98%). Although some MOs attended Oxford or Cambridge, the idea that this was the preferred recruitment base for all Colonial Officers is not applicable to the East African medical cohort. Although Furse strongly favoured Oxbridge recruits for the CAS, the growth of the medical profession with the London and Scottish medical schools as their seedbeds, meant that the narrow educational preferences that were operable for the political service were untenable for the adequate staffing of the medical one. While both Oxford and Cambridge had offered medical degrees since the thirteenth century, the growth of the Scottish medical schools in the eighteenth century and the London medical schools in the nineteenth century, meant that Oxbridge's importance as a key provider of medical graduates had begun to recede. This was particularly the case of Oxford where the medical school did not achieve prominence until after the Second World War. Cambridge, in comparison, already had, by 1900 a large and successful medical school that offered medical degrees with clinical training in London.⁴³ Medical education principally developed around London, Cambridge, Edinburgh and Glasgow. As a pragmatic and long overdue acknowledgment that medical students were drawn from this broader base, the Warren Fisher Committee decided in 1930 that the official medical recruitment policy would correspondingly concentrate its attentions accordingly.⁴⁴

Given this trend in medical education, it is unsurprising that only 57 (13% of those for whom qualifications could be ascertained) MOs went to Oxford or Cambridge Universities as undergraduates; only 10 of these officers had been at Oxford. This reflects the lesser emphasis on medical education at Oxford, but it was also partly due to the greater interest in tropical medical education at Cambridge. From 1904 to 1933 Cambridge University held a diploma course in Tropical

⁴³ L Cole, 'Cambridge Medicine and the Medical School in the Twentieth Century' in A Rook (ed.), *Cambridge and its Contribution to Medicine*, 1971, pp.257-84

⁴⁴ Colonial Office, 'Report of the Committee Chaired by Sir Warren Fisher', *The System of Appointment in the Colonial Office and the Colonial Services*, 1930, p.23

Medicine and had teaching staff with tropical medical interests.⁴⁵ Although most MOs made their career decisions early on, 34 of them had obtained a BA before embarking upon their medical education.

Table 5.1 profiles the spread of highest medical qualifications for the cohort. Significantly, most colonial doctors (45%) had achieved the joint medical bachelors degree (MB, ChB; MB, BS etc.). This indicates that the standard of recruit was generally reasonably high, as the medical and surgical bachelors were commonly regarded as the more difficult and, therefore, prestigious of the medical examinations to take: especially when compared to the qualifications awarded by the medical corporations (i.e. MRCS, LRCP). In part these results only reflect the relative contemporary popularity of the bachelors' degrees; they tally with a sample survey done by Dupree and Crowther of the Scottish medical profession in 1911 that concluded that by far the most popular combination of qualifications for Scottish medical graduates was MB with ChB or CM (86% of their sample).⁴⁶

Highest Medical Qualification	Officer Nos.
Licentiate of the Royal Society of Apothecaries	5
The Conjoint	128
Joint bachelor degree	192
Higher postgraduate degree	84
Other specialist qualification	5
No medical qualification ⁴⁷	1
Medical qualification unknown	9
Total of MOs:	424

⁴⁵ M Weatherall, *Gentlemen, Scientists and Doctors: Medicine at Cambridge, 1800–1940*, Cambridge, 2000, p.163

⁴⁶ Dupree and Crowther, 'A Profile of the Medical Profession in Scotland in the Early Twentieth Century', p.221

⁴⁷ Muriel Robertson was not medically qualified, but had an MA from Glasgow (1906). She got into the Medical Service having been initially seconded to Africa on a Royal Society Commission (see p.179). She appears to have slipped through the net with regard to fulfilling certain entrance requirements. This was perhaps fortuitous, as she was later to become one of the most prominent scientists to have had a Colonial Medical Service career.

Table 5.1: MOs Highest Medical Qualifications

Yet, even if medical and surgical bachelors were universally the most popular route into medicine, the result is interesting with regard to the Colonial Service. In a CO survey of medical qualifications obtained between 1927–9, the Chief Medical Adviser to the CO, Thomas Stanton, concluded that of the 297 candidates surveyed, 266 held on appointment “professional qualifications higher than those required to satisfy the standard for admission to medical practice”.⁴⁸ This indicates that the medical cadre were more highly qualified than was deemed necessary (or even desirable) for the ideal colonial civil servant.⁴⁹ Medical Service recruiters were not looking for top-class candidates, but solid, resourceful and resilient medical men who could be relied upon to represent the Empire in its dispersed locations.⁵⁰ As well as being of a higher calibre than is commonly believed, about a fifth of MOs possessed, or went on to acquire, higher postgraduate medical qualifications. Many of these qualifications were obtained during a period of home leave, often based upon observations collected while in East Africa. Plainly, a significant proportion of MOs were keen to extend themselves and to transform their specialist experiences into further medical qualifications.⁵¹

It is difficult to make any claims about medical school distribution as the information is available for only 152 officers (36%). Of these, the bulk attended London medical schools with the majority coming from St Bartholomew’s (28); St Thomas’ (24); Guy’s and the London Hospital (18 each). The data fit with those of a

⁴⁸ RHL/MSS.Brit.Emp.s.415, Furse Papers, Memorandum: Furse ‘Sources of Supply of Medical Officers 1927–9 (November)’, 09/12/1929

⁴⁹ Deans of various other medical schools were more polarised in their opinions over educational standards. While one (unspecified) Dean complained that the best medical students did not join the Colonial Medical Service, another stated that “amongst his best students” chose the career. PRO/CO/877/7/8 Major Hutchinson, ‘Report on visit to Scottish Universities and Liverpool University’, 07/04/1930

⁵⁰ This is discussed more fully in Chapter 2, pp.73–4

⁵¹ There was also increasing support from the CO for MOs to gain extra qualifications. PRO/CO/850/144/3 ‘Colonial Medical Service: Financial Recognition of Specialist Qualifications, 1939–41’

(pre-Warren Fisher) CO investigation, that concluded that Bart's (the largest London Medical School) was the main London supplier of Colonial MOs.⁵²

With regard to official perceptions of the Colonial Service in general, the predominance of London is interesting. When the Secretary of the London University Appointments Board assessed the reasons why more Oxbridge men than London graduates took up the Colonial Service career he surmised that it was something to do with Londoners' "naturally unadventurous" characters.⁵³ Clearly, with regard to medical recruits, this assessment was far off the mark. However, dominance of London in the Colonial Medical Service was to be expected however, most medical schools were in London, and these attracted students from all over the country.

A sense of the national distribution of medical training can be gleaned from data pertaining to highest medical qualifications (Table 5.2).

Place of origin of highest qualification	Officer Nos.
London	134
Edinburgh	70
Ireland	67 ⁵⁴
Cambridge	33
Other Scottish university	29
Glasgow	25
Other provincial English university	21
Oxford	9
Overseas	7
Place of qualification unknown	29
Total of MOs:	424

⁵² RHL/MSS.Brit.Emp.s.415, Furse Papers, Second memorandum for the Warren Fisher Committee, July 1929; Bart's had a reputation of being the "mother hospital of Empire" K Waddington, *Medical Education at St. Bartholomew's Hospital, 1123–1995*, Suffolk, 2003, p.227

⁵³ PRO/CO/877/4/4 Minute: Furse, [regarding his meeting with Mr Crawford, Secretary of the London University Appointments Board], 10/02/1928. Although this statement is about the Colonial Medical Service in general, not just East Africa.

⁵⁴ Although less written about than the Scots, the Irish were a significant force. Also perhaps related to pressure on jobs in their home country.

Table 5.2: Place of Origin of Highest Medical Qualification

Dupree and Crowther have concluded that the most popular Scottish university for medical degrees was Glasgow; followed by Edinburgh and then Aberdeen.⁵⁵ This is slightly different to the results found in this analysis of Scottish educated Colonial MOs, who mostly came from Edinburgh. This may reflect tropical medical interests in this university medical school—Edinburgh, was the only Scottish institution to offer the Diploma in Tropical Medicine and Hygiene during this period and from 1901 had a lecturer in Tropical Diseases there, Andrew Davidson.⁵⁶ Although London and Edinburgh dominated, provincial university medical schools, such as those at Birmingham, Liverpool and Bristol also figured highly on recruitment profiles, particularly after the 1920s.⁵⁷

The number of MOs with specialist qualifications in Tropical Medicine and Hygiene is surprising: although all Colonial MOs were required to undergo a course in tropical medicine and hygiene before taking up their position, only 230 (54%) of them were listed as possessing the relevant Certificate or Diploma.⁵⁸ Although salary incentives were offered to officers who possessed the DPH (when they became MOHs), only 84 officers (20%) seem to have been attracted by this option. This reflects difficulties that were expressed by central government in 1930 over securing candidates with a DPH. Those who had the qualification appeared to view it primarily as a means of entrance to a public health career in the UK, rather than in the colonial context.⁵⁹

⁵⁵ Dupree and Crowther, 'A Profile of the Medical Profession in Scotland in the Early Twentieth Century', p.221

⁵⁶ *Miscellaneous No.407: Primary Courses of Instruction in Tropical Medicine and Hygiene for Officers Selected for Appointment to the Colonial Medical Service*, 1939, p.1; H Burdett, *Burdett's Hospitals and Charities 1901*, 1901, p.240. Davidson had worked in Mauritius and was author of an influential book, *Hygiene and Diseases of Warm Climates*, Edinburgh, 1893

⁵⁷ RHL/MSS.Brit.Emp.s.415, Furse Papers, Furse, 'Sources of Supply of Medical Officers 1927-9 (November)'

⁵⁸ Although it is likely that the 'real' figure is higher, especially as this was a supplementary qualification and many doctors did not regularly update their *Medical Directory* entries. More definitive cross-checking could be obtained by checking the matriculation records at the London and Liverpool STM&H as well as Cambridge and Edinburgh Medical School records.

⁵⁹ PRO/CO/822/23/1 Memorandum: T Stanton, 11/10/1920

Age at Entry & Prior Experience

The mean age of entry to the East African Colonial Medical Service was 30.⁶⁰ Since this average is skewed by entrants well over the prescribed age, it is more useful to group recruitment ages into bands.

Age Band	Officer Nos.
Band 1: (23–29 years of age)	165
Band 2: (30–39 years of age)	87
Band 3: (40–49 years of age)	18
Band 4: (49+ years of age)	1
Age unknown:	153
Total of MOs:	424

Table 5.3: Age of Entry to EAMS

The commonest age bracket for entry for the Colonial Medical Service was between 23 and 29 years (Table 5.3; 27 was the most common entrance age among that group). This was in line with official age requirements which, although fluctuating, generally required medical candidates to be between 23 and 35.⁶¹ Official policy stated a preference for MOs who had obtained a couple of years' hospital experience before applying for a Medical Service position.⁶² Nevertheless, this was not always the case — some MOs joined at 23 on graduation, and sometimes, especially when specialists were needed, much older candidates were appointed. Henry Gordon joined the Colonial Medical Service as a consultant psychiatrist at the ripe age of 65.⁶³ Particularly before 1930, older experienced candidates were

⁶⁰ This figure is based upon an average for those officers for whom the information could be obtained. Date of birth was established for 271 (64%) of officers.

⁶¹ See Chapter 2 for the intricacies of the changing age requirements. 'Information as to Colonial Appointments', in *The CO List, 1899*, pp.346–8, p.347; *Miscellaneous No.99: Colonial Medical Appointments*, 1921 [29th Ed.], p.3

⁶² 'Information as to Colonial Appointments', *The CO List, 1899*, pp.346–8, p.347; Also PRO/850/71/13, T Stanton to JA Drake, 14/11/1936

⁶³ Eg, Arthur Boase, John Davies, Clarence Howat, Thomas Lawson, and Alan Maclean all joined the Colonial Medical Service aged 23

sometimes employed on a temporary basis to fill staff shortfalls.⁶⁴ These older recruits were often seconded from other organisations, such as the RAMC or the Royal Society Sleeping Sickness Commission. During the early years of colonial establishment in East Africa older officers who had formerly worked for the IBEAC to the Colonial Service were also employed.⁶⁵

In all, 301 officers (71%) had some documented professional experience before taking up their colonial medical position — although, the figure may be an underestimate, since prior experience is not always mentioned.⁶⁶ This high figure does however seem to indicate CO preference for more professionally mature doctors. Of the 301 known to have previous professional experience, 153 (51%) listed a hospital residency of some sort before they applied to the Colonial Medical Service, and 185 (61%) had military medical experience, usually in the First World War.⁶⁷ Many Colonial MOs had formerly worked in Africa or India, or belonged to a colonial family. 120 officers (40%) claimed some such colonial experience, whether in a professional capacity or via the circumstances of their upbringing, supporting the contention that the colonial type was one imbued with a belief in the tradition of Empire.⁶⁸

Most recruits 323 (76%) came to East Africa as their first government appointment — only 70 (16.5%) had been in another branch of the Colonial Medical Service, or in the IMS, before appointment in East Africa (54 of this 70 had been previously employed specifically by the Colonial Service). For 47 officers it is not known whether East Africa was their first posting or not.

⁶⁴ Eg, Ernest Cooke (44); Frank de Smidt (37); Geoffrey Gibbon (37); William Lamborn (40); Walter MacDonald (36)

⁶⁵ Eg, William Ansorge (45) or Aubrey Hodges (37)

⁶⁶ As doctors supplied the information for *Medical Directory* entries, it is likely that they did include all their professional experiences, as this added to their public profile.

⁶⁷ These figures come to more than 100% as some officers had *both* military and professional experience.

⁶⁸ As discussed in Chapter 2, Furse preferred to recruit these types.

Length of Service

Start date information has been found for 421 (99%) of MOs and in 347 (83%) cases retirement dates were also found.⁶⁹ Once in the medical service, the average length of service was eleven years; close to the minimum length of time an officer had to serve before qualifying for a gratuity (Chapter 2). Since the average is skewed by very long and very short periods of service, it is again useful to look at the data in different bands (Table 5.4).

Length of Service Band	Officer Nos.
Band 1: (0–2 years service)	74
Band 2: (3–9 years service)	107
Band 3: (10–19 years service)	85
Band 4: (20–29 years service)	74
Band 5: (30+ years service)	8
Length of service unknown:	76
Total	424

Table 5.4: Length of Service in East Africa

A large proportion of entrants saw the Colonial Medical Service, as the recruiters would have wished, as a long-term career.⁷⁰ The spread of figures between long and short service is remarkably even: 181 Officers stayed under ten years, while 167 stayed for ten years or more. It appears that the Colonial Medical Service selection methods were remarkably accurate in terms of suitability: over a 46-year period only 19 officers left the service after a year or less. The longest serving officer was Cliff Braimbridge who was in East Africa for 36 years. The figures should be used with some caution as they do not differentiate between officers who left the Colonial Medical Service and those who transferred to a colony outside Kenya, Uganda and Tanzania. Many senior officers transferred to other colonial dependencies later in their careers (see Appendix 5). Officers such as John Buchanan

⁶⁹ The information calculated for this section is based on *first* retirement dates, as sometimes officers retired and then subsequently rejoined the Service. For the service dates of individuals, see Appendix 3

⁷⁰ PRO/850/71/13 'Note of a Meeting held in the Colonial Office Between Representatives of the Colonial Office and a Deputation from the Dominions Committee of the BMA, 06/01/1937

and William Lamborn had extremely lengthy Colonial Service careers, although they spent large proportions of them in other territories.

Honours and Fellowships

Brief mention should be made on the subject of awards and fellowships. In 1938 Charles Jeffries was able to encourage prospective recruits that “every New Year and Birthday Honours List contains the names of numerous members of the Service”.⁷¹ This claim is certainly borne out by the evidence, as 86 (20%) of MOs received a formal decoration or honour from the British Government for their services to Empire. The most common decoration was the CMG (Companionship of the Order of St. Michael and St. George), followed by the Companionship of the Imperial Service Order; some officers were also knighted or received an OBE (Order of the British Empire) for their services.⁷² Notably, no KCMG (Knight Commander) or GCMG (Knight’s Grand Cross) were awarded to any of the officers profiled in this study. This is not entirely surprising, as these decorations, were usually conferred only upon Governors or very senior officials. Service in World War One also meant that a significant number of officers (72) received military titles, clasps or honours: usually orders of chivalry such as those of St. Michael or St. George. These were typically gained either in the Boer War or the African campaigns of World War One.

Another important marker of professional recognition was the award of a Fellowship of prestigious bodies such as Royal Colleges of Physicians or Surgeons in England, Ireland and Scotland. 41 (10%) MOs achieved Fellowships of Royal Colleges.⁷³ A couple of important medical researchers, namely Percy Garnham and Muriel Robertson, were awarded the prestigious FRS.

Titles and honours conferred by the State were tangible symbols of inclusion into the imperial system. The awards bestowed a uniquely British tribute and were a visible encouragement to conform to the conservative, class ideals of imperial

⁷¹ C Jeffries, *The Colonial Empire and its Civil Service*, Cambridge, 1938, p.127; “[T]he most successful British proconsuls and imperial soldiers were knights and peers several times over, veritable walking Christmas trees of stars and collars, medals and sashes, ermine robes and coronets”. Cannadine, *Ornamentalism*, p. 95

⁷² See Appendix 5

⁷³ Including FRCPsych; FFARCS and FRSTM

governance. The fifth of MOs who were awarded such accolades were physical reminders to their colleagues of the whole group's ultimate allegiance to the British monarch, and helped to promote a sense of common belonging and collective participation for colonials in the far-flung corners of Empire. David Cannadine has made a similar point: the British honours system in the colonial context, he argued, "created and projected an ordered, unified, hierarchical picture of Empire".⁷⁴ Fellowships were a conferral of professional honour, normally based upon scientific knowledge. They were an important way of accrediting work done in the colonial locations by tying MOs into the prestigious accolades system of the home country.

* * *

The collective identity of Colonial MOs built on their shared profiles. Although individual experiences were necessarily distinct, rationales varied, and circumstances changed, the medical cohort embodied similarities that bound them together above their differences. Most entered the career under 30 years of age, and it was usually their first Colonial Service posting. This was, by and large, a young, impressionable group whose subsequent careers became inextricably bound to their shared early initiation to Africa. Most officers were from mixed class backgrounds and they had all completed a broadly similar medical training. The bulk had professional medical experience in other spheres; several came from colonial backgrounds; they were also, it should not be forgotten, mostly men (Chapter 4). Within this group there were, of course, many sub-groups. People formed local communities united by their common nationalities, age bands, *alma mater*, as well as regional posting and personal interests.⁷⁵ Yet, over and beyond the bonds created through backgrounds and origins, came broader, further reaching, ideological similarities that were articulated after MOs were established *in situ* as government officials. These ideologies were drawn from their shared conceptions and experiences of government service, their membership of the (tropical) medical profession, their implicit ideas of racial

⁷⁴ Cannadine, *Ornamentalism*, p. 98

⁷⁵ Eg, Anderson was pleased to note that "three of the eight oarsmen in the 1914 Cambridge Crew were in Kenya" when he arrived there in 1925. RHL/MSS.Afr.s.1653, TF Anderson, *Reminiscences by T Farnworth Anderson*, Book I, Kenya, 1973, p.15

superiority, and, most importantly, their distinctive expressions of ultra-British, and yet specifically British East African, behaviour.

5.3 Colonial Medical Communities

A colonial medical identity developed partly because of the distance from centralised control that most Colonial Officers experienced (Chapter 4). This, coupled with a cumbersome Civil Service bureaucracy, meant that dialogue between the ruling centre and the colonial periphery was notoriously slow.⁷⁶ A notable gap existed between central government and field officers, which created powerful circumstances, as Philip Curtin has argued, for those ‘on the spot’ to develop perspectives different from their contemporaries back home.⁷⁷

Even if MOs could expect to enjoy a considerable amount of professional independence in the field — with few visits from senior staff and relatively little accountability — this did not preclude — indeed it strengthened the need for — the existence of further-reaching, shared ideologies. Living in widely dispersed communities, as a racial minority in an alien place, MOs quite naturally identified with others in similar situations to themselves.

United by Service

Most obviously, MOs were united by their membership of the Colonial Service. Employment by this single agency enrolled employees as part of the new governing classes in Africa while including them in a long established British tradition. This affected the way officers identified themselves and their colleagues, and differentiated them from other sectors of colonial society, such as the religious missions, or those that owned large farms. MOs ‘right’ to be in Africa was validated through their government employment. They were part of a sturdy administrative tradition connected by implication, if not directly, to a continuous line of British service overseas originating in India in the sixteenth century. Regardless of the extent to which individuals connected spiritually or professionally with their place of posting,

⁷⁶ R Hyam, ‘The Colonial Office Mind 1900–1914’, *JICH*, 8, 1979, pp.30–55

⁷⁷ PD Curtin, *The World and the West*, Cambridge, 2000, p.49

their ultimate rationale for being there, and therefore, their critical allegiance (if they wanted to keep their jobs), had to be with the British Government they served.⁷⁸

The CO quite self-consciously used the rhetoric of collective belonging as a means of encouraging uniform behaviour in its employees. Official circulars issued by the CO to Colonial Service officers often used rigorous, emotive language to emphasise the importance of maintaining standards of conduct in the field for the sake of the collective propriety of the Service as well as of individual integrity.⁷⁹ Civil service tradition provided the rationale for officers to set a good example to their colleagues: both in loyalty to those that had served before them and as a precedent to those that would serve after.

Absorption into the Colonial Service tradition can be identified from the very earliest stages of recruitment. The selection system was centrally devised to facilitate continuity of attitude among officers. Furse was quite explicit that one of his foremost ambitions was to inculcate a tradition of Colonial Service similar to that enjoyed by the ICS or the Sudan Political Service. He was looking to recruit types that would uphold prestige and cultivate collective pride in the institution, which he felt had hitherto not had the public recognition it deserved.⁸⁰ A sense of common culture was encouraged by channelling all applications through the same uniform paths and aiming to select types in accordance with conservative ideals. One of the noteworthy results of the recruitment process was that being deemed suitable by the interviewers fostered a sense of privileged belonging and collective pride. Generally most officers actively wanted to be in the Service and felt honoured to have been chosen. No officers (who left memoirs) gave any indication that they had been forced to join the Service against their will or that it was in any way a career of which to be ashamed.

⁷⁸ McKay has argued that officers in Tibet were fundamentally bound by a sense of duty “above any consideration for the Tibetans”. McKay, *Tibet and the British Raj*, p.192. This is not to say that Officers never complained, rather they were ultimately constrained in how they could do so.

⁷⁹ PRO/CO/850/47/4 Lord Crewe, Confidential Circular, 11/01/1909; RHL/Mss.Afr.s.1079, Papers of IC Middleton, ‘Memorandum on the Subject of the Acceptance of Business Appointments by Officers of the Crown Services’, 07/1937

⁸⁰ R Furse, *Aucuparius: Recollections of a Recruiting Officer*, Oxford, 1962, p.222

As will be discussed in the next section, the shared tropical medical training in which all MOs participated helped to determine the type of professional interests and affiliations the colonial medical group had. It was also an early means of establishing an *esprit de corps*, similar to that engendered by attendance at the Tropical African Training Course (for Administrative Officers) at Oxford or Cambridge before departure.⁸¹

Other collective rituals were undergone before embarkation. The most emblematic rite of passage to the exotic life was the obligatory trip to the tropical outfitters (see Chapter 3). Many MOs recalled the money they spent on tropical paraphernalia before they went away and numerous advice books listed the lengthy (so-called!) minimum kit necessary for those venturing abroad.⁸² Philip Mitchell, former Tanzanian District Officer (later governor of Uganda), provided one of the best examples of this pre-departure experience that typified most colonial departures:

We bought...vast pith helmets, spine pads, cholera belts and the Lord alone knows how much other junk....You could buy anything a man really needed, at half the prices paid in London, in the general stores of any African colony—but again, nobody told us that, in London; and if we had been told we would not have believed it. For the truth is, we all felt like a lot of young Stanleys and Spekes and the more exotic and peculiar the things we bought, the more we felt like intrepid explorers bound on some romantic ‘Mission to the Interior’.⁸³

Once on the ship to East Africa officers would have felt part of a shared adventure. The long sea voyage provided an extended opportunity to meet fellow doctors about to start colonial service (or rejoin after leave). The voyage also afforded an opportunity to meet officers in other branches of the Colonial Service. Arthur Williams remembered that on his outward trip “[n]early all passengers were in some

⁸¹ Schemes were also aired to start a Colonial Service club in London. This scheme, although principally for educational, veterinary, police and customs probationers, hoped to include MOs who were taking the DTM&H at the London School. This encouraging pre-departure group identification between Colonial Service probationers. PRO/CO/877/18/7 ‘Proposed Formation in London of Colonial Service Society’, 1938 For the importance for early bonding of CAS candidates see C Jeffries, *Partners For Progress: The Men and Women of the Colonial Service*, 1949, p.84

⁸² Eg, WJ Simpson, *The Maintenance of Health in the Tropics*, 1905; RHL/MSS.Afr.s.1782, A Hodges, Diaries 1898–1907, 17/02/1898; RHL/MSS.Afr.s.1872/144b Hugh Trowell, interviews, tape 1B, [n.d. c.1984], p.3

⁸³ Mitchell joined the CAS in 1912. P Mitchell, ‘Forty Years Back’ in A Kirk-Greene, *Glimpses of Empire: A Corona Anthology*, 2001, pp.278–80, p.279

East African Service or other”.⁸⁴ It was, therefore, undoubtedly a socially very useful trip and many of the early acquaintances made in this way endured throughout subsequent careers.⁸⁵

Early shared experiences helped to nurture a sense of pride and belonging. The CO itself was well aware that “[t]he most important training was thought to take place during the early years of Colonial Service” and saw the benefits of recruiting officers while relatively young when they were unlikely to have well developed separate (or even contrary) ideological commitments.⁸⁶ This correlates with Henrika Kuklick’s sociological analysis of CAS careers in the former Gold Coast. Kuklick concluded that those who joined the Service young tended to be the ones who ultimately had the longest careers and attained the highest-ranking positions, while officers with shorter lengths of service were more likely to express dissatisfaction.⁸⁷ If Service ideas were imbibed while young, they were more likely to engage people with the whole ethos of the Colonial Service.

As soon as the new appointees arrived in East Africa they were made to feel part of an organised establishment — although it was impressed upon the new arrivals that they were unmistakably juniors within that group. The idea that officers had to look to their seniors for examples of social and professional conduct was tacitly accepted, and mentoring (usually at one of the main hospitals in the nearest urban centre) was the most popular way of showing young officers ‘the ropes’.⁸⁸ Early conventions of arrival would involve meeting with a senior official, and then discussing over a sundowner, fundamental bureaucratic requirements as well as “the

⁸⁴ RHL/MSS.Afr.s.1872/153a AW Williams, ‘Detailed Memoranda on Experiences in the Colonial Medical Service in Uganda and Tanganyika, 1931-1949’, [n.d. c.1983], p.3

⁸⁵ RHL/MSS.Afr.s.1872/33 ACE Cole, ‘Memorandum on Experiences in the Colonial Medical Service in Tanganyika, 1939-60’, 10/04/1983; HG Calwell, ‘Nineteen Years in the Colonial Medical Service’, *UMJ*, 65 (supplement), 1993, pp.(s)1-(s)42, p.(s)2

⁸⁶ PRO/CO/877/6/10 ‘Recruitment of Candidates for the Home and Colonial Services: Proposal to Hold a Joint Competitive Examination’, c. 05/06/1929

⁸⁷ Kuklick, *The Imperial Bureaucrat*, p.89, p.117

⁸⁸ This was absolutely typical and references are too numerous to mention. A couple of published examples include: R Scott’s assistantship to W Lamborn. RR Scott, ‘The Growth of a Public Health Service in a Tropical Town’, *EAMJ*, 10, 1933-4, pp.130-44, p.133; C Braimbridge also used to regularly take new recruits under his wing to give them surgical experience. ‘Address by Mr CV Braimbridge’, *EAMJ*, 31, 1954, pp.205-8, p.207

peculiarities of the organisation”.⁸⁹ In Kenya, new MOs were given typed-up notes telling them how to prepare food, appoint suitable servants and take precautions against the disease and the sun.⁹⁰ In some ways, these were unremarkable, routine, welcoming procedures, except that they were crucially connected to the somewhat rigid expectations of Service conduct and requirements. Young officers were effectively introduced to accepted norms of behaviour and attitude — a period of orientation that one MO wryly recalled as having been one of both “acclimatisation and indoctrination”.⁹¹ This form of professional initiation into the colonial life was not just evident in the Colonial Service in Africa. David Potter for example, has shown how young recruits to the ICS were ‘shaped’ through on-the-job training and encouraged to conform to certain standards and types.⁹²

Colonial Service Officers were all subject to the same rules and regulations and all had their colonial careers assessed via a regular system of confidential reports.⁹³ Officers shared an institutional experience and one that was quite conscious of its prominent rôle in the shaping of official British (and African) history. The Colonial Service provided new recruits with a formidable ideological framework; one that they would not have benefited from had they gone to Africa to seek their fortunes independently. Many features of daily life were seen to and regulated by this protective body. Employees’ housing was provided and furnished by the Public Works Department, officers were recommended to join the nearest European club (even if they then moved into the outlying districts) and everyone was issued with regulations establishing codes of behaviour.⁹⁴ If the Colonial Officer was allotted a district posting, the community in which he lived was called the *boma* (Swahili for stockade or enclosure). Many officers identified this as the most important social unit of the district-based Colonial Service, with officials from

⁸⁹ RHL/MSS.Afr.s.1872/33 Cole, ‘Memorandum on Experiences’

⁹⁰ KNA/MOH/1/8020 ‘Medical Notes to Officers appointed to BEA’, 17/07/1920

⁹¹ RHL/MSS.Afr.s.1872/153a Williams, ‘Detailed Memoranda’, p.7

⁹² DC Potter, ‘The Shaping of Young Recruits in the Indian Civil Service’, *IJPA*, 23, 1977, pp.875–89

⁹³ These annual reports significantly asked PMOs for comment on “personal character and social qualifications” KNA/MOH/3/769 Copy of an empty Confidential Report, [n.d. c.1940s]

⁹⁴ Wiggins immediately on arrival took up the Secretaryship of the Mombassa Club. CA Wiggins, ‘Early Days in British East Africa and Uganda’, *EAMJ*, 37, 1960, pp.699–708, p.700

various branches of the Service forming a European enclave physically distinct from the African communities around them.⁹⁵ It was around the *boma* that mutually identifying communities developed, not only forging friendships and lifelong loyalties; it was also the site of acrimonious internal feuds and rivalries.⁹⁶

Despite personal and professional disputes, accord and unity were the Colonial Service's over-riding strength. Senior officials actively pursued a policy that suppressed certain types of treachery and discord and purged undesirables. An unspoken distinction operated between 'acceptable' and 'unacceptable' complaints. 'Acceptable' complaints were pursued through customary pathways, which for MOs was their local branch of the BMA.⁹⁷ It was tolerable for officers to agitate for improved terms and conditions of service; seeking these ends was perceived as being for the collective good. This was quite different from individual insubordination or misconduct that, in contrast, was dealt with summarily and, often, heavy-handedly. The examples are numerous: when Hugh Trowell complained about the effectiveness of medical safaris he was threatened with a posting to the remote desert region of Kenya, the Northern Frontier District;⁹⁸ when Margaret Lamont complained about the policy of enforced venereal disease examinations of African women, she was dismissed;⁹⁹ Harvey Welch and Ernest Adams were 'got rid of' because their alcohol and drug addictions.¹⁰⁰ Above all else, the Colonial Service worked towards presenting a united and decorous front.

⁹⁵ For a description of typical *boma* see JA Carman, *A Medical History of the Colony and Protectorate of Kenya: a Personal Memoir*, 1976, p.31; M Trowell, *African Tapestry*, 1957, pp.18–20

⁹⁶ Eg, the priority dispute between Clearkin and Gilks. RHL/MSS.Afr.S.1872/30 Peter Alphonsus Clearkin, 'Tropical Typhus', p.4; Trowell described a bitter personal feud within a small *boma* in Kenya. RHL/MSS.Afr.s.1872/144a HC Trowell, 'Detailed Memorandum on Service as a Medical Officer, Lecturer in Medicine and Specialist Physician in Kenya and Uganda, 1929–57', [n.d. c.1984], p.5

⁹⁷ The deputations made on behalf of MOs by the BMA are discussed in Chapter 4 (p.174–6).

⁹⁸ WL/CMAC/PP/HCT/A5 E Bray, *Hugh Trowell: Pioneer Nutritionist*, unpublished biography, 1988, p.4; [Chapter 4] p.17

⁹⁹ AR Cook, 'The Medical History of Uganda: Part 2', *EAMJ*, 13, 1936–7, pp.99–110, p.100

¹⁰⁰ KNA/MOH/1/1468 Commissioner, Entebbe to J Will, PMO, Uganda, 05/09/1905

Other historians have commented upon the tendency for self-regulation within colonial societies.¹⁰¹ The EAMS was really no special case in this regard and the evident culture of self-censorship was linked to the intrinsic conservatism of the Colonial Service as a whole. As one commentator noted: “the *esprit de corps* of the Colonial Service, or red tape, as it is sometimes termed, is so rigid and dangerous to the prospects of those who transgress its canons that seldom indeed is there friction”.¹⁰² This is not to say that everyone accepted blindly the rule and attitudes of the CO. People *did* complain, and were further united in their shared frustration. But ultimately most felt aggrieved by such a formidable institution such as the Colonial Service. Percy Garnham (one of the most famous malariologists to come out of the EAMS) summed up what must have been the feelings of many. He (privately) bemoaned:

[The] tone of the Service, which necessitates (for advancement within it), a blind devotion to doctrines and theories to which one personally is completely averse. (in [*sic.*] order to be looked upon with favour, one must subscribe blindly to the prevailing doctrine, just as a Nazi must in Germany or a fascist in Italy).¹⁰³

Employees’ identification with the Colonial Service usually stayed with them long after they had retired. In the United Kingdom, the Corona Club, an official Colonial Service and Colonial Office club was established in 1900 to provide a setting in which current and retired officers could share their colonial experiences. The Corona Club had a membership that grew from over a thousand in 1905, to over four thousand by 1958 and, although it was not characterised by plentiful meetings, it provided an important focal point for individuals who had been (or were) part of the ruling classes of Empire.¹⁰⁴ Between 1948 and 1962 the club published a journal,

¹⁰¹ “The [Tibetan] cadre spoke with one voice and that unity was a part of its strength....they deliberately suppressed alternative perspectives”. McKay, *Tibet and the British Raj*, p.205; Also Kennedy, *Islands of White*

¹⁰² A Davis, *A Microcosm of Empire (British East Africa)*, Nairobi, [n.d. c.1918], p.67

¹⁰³ WL/CMAC/PP/PCG/A2 PCC Garnham, Personal Correspondence and Miscellaneous, 1936–44 [untitled, undated notes c.1939]

¹⁰⁴ A Kirk-Greene, *The Corona Club: an Introductory History*, 1990; Kirk-Greene, *On Crown Service*, pp.257-8

Corona, the delivery of which was looked forward to by officers in outstations and provided further tangible evidence of their collective membership of a group.¹⁰⁵

Other forms of media served consciously to tie Colonial Service employees together. In 1932 the BBC began broadcasting to Africa and other parts of Empire via the Empire Service, the forerunner of the BBC World Service.¹⁰⁶ These programmes connected officers in the localities with others in similar situations to themselves; they also actively promoted the Colonial Service by broadcasting the speeches of the annual Colonial Service dinner of the Corona Club.¹⁰⁷ Other schemes looked after colonial officers in their retirement. The Osborne Convalescent Home on the Isle of Wight provided facilities for ex-colonial officers and in 1967 the Overseas Pensioners Association was established.¹⁰⁸

The Colonial Service, in short, deliberately nurtured a group culture. Recalcitrant individuals were mostly silenced by dismissal or by allocation to a less desirable posting. This discouraged individual freedom of expression, but it brought with it large social and experiential rewards — not least, membership of a prestigious ruling class, support from British government and, at the height of Empire, the implicit support of the British people. Before World War Two, officers felt little need to doubt that they were undertaking good and worthy government duties. Doctors were clearly influenced by their strong Colonial Service identity, but their membership of the medical fraternity provided them with another important mutual reference point.

United by Profession

Colonial Officers associated at a general level with all their Colonial Service colleagues, but naturally migrated towards the same vocational corps as themselves.¹⁰⁹

¹⁰⁵ Kirk-Greene, *Glimpses of Empire*

¹⁰⁶ On Christmas Day 1932, King George V gave the first royal broadcast to the Empire, scripted by Rudyard Kipling. <http://www.bbc.co.uk/heritage/story/1930s> (Accessed 17/05/2004)

¹⁰⁷ Jeffries, *Colonial Empire*, p.14

¹⁰⁸ PRO/323/985/4 Circular: LS Amery, 'Osbourne Convalescent Home', 22/02/1927

¹⁰⁹ For a sociological examination of this see HS Becker and JW Carper, 'The Development of Identification with an Occupation', *AJS*, 61, 1956, pp.289-98

Even in areas where Europeans were widely dispersed, the Colonial Officer identified with his or her counterparts in other regions; if this was not always practicable (as it often was not) the option remained for the isolated individual to identify himself or herself with the profession that they officially represented. Just as the District Officer (DO) became the symbol of regional authority, embodied in a single individual, so the doctor became the symbol, for many Europeans and Africans, of health and (western) medical adeptness.¹¹⁰ In colonial society, officers frequently found themselves in situations where they were the only administrator, doctor or veterinarian for miles around — although these single representatives of the various Service branches, may all have lived together in the same *boma*. Personal identity became profoundly, and often interchangeably, linked to their professional standing; creating a situation that made it “difficult for an officer to get away from an atmosphere of ‘shop’”, unable to “leave his work behind him when he quits his office in the evening”.¹¹¹

Arguably, this professional identification was particularly strong in the case of medicine. Doctors were reminded through the Hippocratic Oath that they were part of a sacred fraternity, bound together under the same codes of conduct and terms of reference.

All who follow the calling of medicine, varied as their work may be, constitute a single brotherhood bound together by common interests and aims. The spirit of comradeship, which counts for so much in student days, should be preserved, both for its own sake and because no doctor can safely hold himself aloof from his fellows.¹¹²

Medicine, like the church, was seen to be a calling and however far apart different doctors might find themselves, they were ultimately all seen as individual representatives of the ancient Aesculapian tradition. After the unification of the EAMS in 1921, and the overall unification of the Colonial Medical Service in 1934, the bonds between Colonial MOs were cemented through closer institutional union. Before that point, colonial doctors expressed their collective identity, principally

¹¹⁰ A Kirk-Greene, *Symbol of Authority*, [forthcoming], December 2004

¹¹¹ Jeffries, *Colonial Empire*, p.125

¹¹² ‘Numbers of the Medical Profession’, *BMJ*, ii, 1931, pp.414–18, p.418

through the commonalities created by their shared African location and exposure to similar place-specific medical problems. They were also, significantly, tied together ideologically through their participation in formative training in tropical medicine and hygiene.

The course in tropical medicine and hygiene that MOs were required to undertake, regardless of posting, prepared colonial doctors for a generic tropical medical world.¹¹³ By formally training doctors in the new and developing specialism, the British colonial government was effectively producing the first official messengers of metropolitan-taught tropical medicine, a subject that was ignored in most medical school and university courses.¹¹⁴ Douglas Haynes has argued that the establishment of the London School (and to a lesser extent, the Liverpool School) in 1899 marked the turning point in the history of tropical medicine; mostly because it “brought to a head nearly a half century of tension between the medical profession and the imperial state over the social production of imperial doctors”.¹¹⁵ Haynes’ argument supports this chapter’s theme of a collective colonial medical identity. The official sponsorship of tropical medical training marked the point where government began to exert influence over the type of knowledge that official doctors would be using. The establishment of special institutions to train officers was, in the wider perspective, an initiative to unite all MOs in a common purpose.¹¹⁶ This additionally aligned the Colonial Medical Service with a certain amount of medico-scientific modernity, and nurtured group allegiances based upon shared participation in a new and developing field. This project, above all, allowed government to oversee the training of MOs who were to be dispersed throughout Empire. It gave them some

¹¹³ In 1907 the Liverpool School modified and extended the curriculum in line with the precedent established in London, from a 10-week course to a 13-week course. JWW Stephens, W Yorke, and B Blacklock, *Liverpool School of Tropical Medicine, Historical Record: 1898–1920*, Liverpool, 1920, p.38; Also H Power *Tropical Medicine in the Twentieth Century. A History of the Liverpool School of Tropical Medicine*, 1999

¹¹⁴ Albert Cook acerbically remembered: “Our training in specifically tropical diseases at Cambridge and Bart’s was nil” Cook, ‘The Medical History of Uganda: Part 1’, p.77

¹¹⁵ DM Haynes, *Imperial Medicine: Patrick Manson and the Conquest of Tropical Disease*, Philadelphia, PA, 2001, p.124

¹¹⁶ It was the London School (not Liverpool) that was seen as the government’s brainchild. Although it is acknowledged that other groups attended the tropical medical courses, particularly missionaries, the original intention to establish the London School was the result of a long debate over how the training of Colonial MOs should be conducted.

sort of theoretical control over the way Britain would be medically represented abroad and ensured that all doctors were trained to believe in collective and common goals within the broad framework of British colonial policy.¹¹⁷ Uniformity was an important stabilising element in a geographically and culturally diverse Empire. In the medical sphere at least, this homogeneity of approach was chiefly achieved by channelling all appointees through specialist training at a specialist training facility.¹¹⁸

The curriculum of the London School in the early days centred more upon clinical training than laboratory work.¹¹⁹ The core textbook was Manson's *Tropical Diseases: A Manual of the Diseases of Warm Climates* (1898). Protozoology and helminthology were initially seen as more essential than bacteriology, which was not added to the syllabus until 1913.¹²⁰ It was only after 1919 that the curriculum began to include detailed instruction on tropical hygiene. Even after improvements to the curriculum, many officers found the tropical medical instruction poor and of only limited relevance, but relevant or not, collective participation on the course had vital symbolic power.¹²¹

The establishment of the London school was a politically centralising move, but it also offered a reasonably cost-effective solution to a problem that had been expressed within the medical press for some time. With an estimated one in five British medical graduates heading for a career in the tropics, there had been calls for a special training to unite Colonial MOs since the end of the nineteenth century.¹²² This shared inter-territorial involvement in a growing area of expertise was actively promoted by the CO and its supporters as making the Colonial Service career an attractive one for ambitious young doctors and furthermore resulted, by the 1920s, in

¹¹⁷ It was, furthermore, politically useful to support colonial scientific endeavour. See M Worboys, *Science and British Colonial Imperialism: 1895-1940*, University of Sussex, DPhil. Thesis, 1979, p.402

¹¹⁸ Just as the IMS and the RAMC did in their collective training at Netley.

¹¹⁹ A Castellani, *Microbes, Men and Monarchs: A Doctor's Life in Many Lands*, 1960, p.28

¹²⁰ P Manson-Bahr, *History of the School of Tropical Medicine in London: 1899-1949*, 1956, focus on protozoology and helminthology p.7; inclusion of bacteriology p.54

¹²¹ RHL/MSS.Afr.s.1872/9 RE Barrett, 'Memorandum on Experiences in the Colonial Medical Service in East Africa, 1928-55', 1983, p.1; RHL/MSS.Afr.s.1872/153a Williams, 'Detailed Memoranda', p.2

¹²² D Duckworth, 'On the Education of Medical Practitioners for Colonial Service', paper read at the First Intercolonial Medical Congress, Amsterdam, 1883, pp.1-7, p.1; P Manson, 'On the Necessity for Special Education in Tropical Medicine,' *Lancet*, ii, 1897, pp. 842-5; also, Manson-Bahr, *History of the School of Tropical Medicine in London*, p.31

the emergence of colonial scientific communities beginning to develop autonomously from Britain.¹²³

This shared training experience, however, was only the start of mutual identification between Colonial MOs. Once in the colonies, doctors further expressed their common identity through their membership of the East African branches of the BMA or via the pages of the most important local medical journal, *The East African Medical Journal (EAMJ)*. These physical reminders of the existence of a medical community, all firmly established by the 1920s, helped to bind together members of the same profession practising similar types of medicine in comparable conditions.¹²⁴

The BMA actively promoted its branches as a means of locally nurturing a sense of common cause.¹²⁵ It explicitly hoped, through branch meetings and widespread distribution of the *BMJ*, to include the colonies in a feeling of common “kinship” with the home countries. Doctors were to gain strength from being part of a wider professional group that went over and above the “distance which divides one part of the Empire from another”.¹²⁶ Furthermore, not only did BMA branch meetings foster a sense of inclusion with the British medical profession at large, they also created a forum in which local identity, “unity and vitality”, could be celebrated.¹²⁷ Although membership of the local branches of the BMA was open to all members of the medical profession, whether private practitioners, commercial doctors or missionaries, government doctors were particularly prominent. Many Colonial MOs were also BMA branch presidents.¹²⁸ The local branch was usually the

¹²³ Worboys, *Science and British Colonial Imperialism*, pp.191–243

¹²⁴ In 1913 a combined Ugandan and Kenyan Branch of the BMA was founded, after 1920 these two branches separated and two individual branches in Uganda and Kenya were formed. The Tanzanian Branch was established in 1923.

¹²⁵ ‘Numbers of the Medical Profession’, *BMJ*, ii, 1931, pp.414–18, p.418

¹²⁶ ‘The Association and the Colonies’, *BMJ*, i, 1905, p.1394

¹²⁷ ‘Editorial’, *KMJ*, 2, 1925–6, p.299

¹²⁸ Past (Colonial Medical Service) Presidents of the Kenya Branch during this period included: Clare Wiggins, John Carman, John Gilks, Henry Gordon, Christopher Wilson, Albert Patterson; of the Uganda Branch: Clare Wiggins (again); Clifford Roberts; of the Tanzanian Branch: John Davey, William Connell

first point of referral for Colonial Service complaints and it frequently acted as an arbitrator between the profession and the government (see pp.174–6).

One of the most important stages of the development of a scientific community in East Africa was the establishment in 1923 of the *Kenya Medical Journal* (*KMJ*).¹²⁹ This periodical had originally been intended solely for Colonial Medical Service staff in Kenya: to give them a forum in which to share their professional ideas, but also to act as a unifying force to doctors posted far and wide within the region. The *KMJ* reported meetings of the local branches of the BMA, made announcements of particular interest to Medical Service staff and detailed officers' movements to, from, and within the colony. In fact, the journal quickly became more generalist in its remit and expanded beyond the borders of Kenya to represent the broader European medical community throughout East Africa, including private and missionary doctors.¹³⁰ The MO responsible for setting up and editing the journal was Christopher Wilson, a man of outspoken and candid opinions, who went on, in his retirement in Kenya, to write two political works on the country. With the benefit of hindsight, it was entirely characteristic for him to have started a publication that gave voice to local opinions.¹³¹ Over time the newsy format subsided and became replaced with the more serious professional tone, with an emphasis on publishing local research findings that still survives today.¹³² Significantly, in the period covered by this study, Colonial Medical Staff featured prominently amongst its editors, even after it had broadened its sphere to become a mouthpiece for the East African medical profession at large.¹³³ Officers also used this journal to report local findings or the results of trials.

¹²⁹ This journal underwent numerous name changes: *KMJ* (1923–4); *K EAMJ* (1924–32); finally the *EAMJ* (1932–present).

¹³⁰ Although the *EAMJ* became more generalist in its readership between 1923–c.1945, from the 1950s onwards (and in keeping with growing expectations of specialist journals) it became markedly more technical: containing published papers and book reviews, but very little of its former lively editorial comment or local colour.

¹³¹ 'Christopher Wilson', *BMJ*, i, 1956, p.692

¹³² MJ Dobson, M Malowany, K Ombongi and R Snow, 'The Voice of East Africa: The East African Medical Journal at its 75th Anniversary', *Tr.RSTMH*, 92, 1998, pp.685–6, p.685

¹³³ Colonial Medical Service editors were: Christopher Wilson (1923–7); John Carman (Asst. Ed. 1927–45; Ed. 1945–60); John Gilks (1927–30)

The *EAMJ* was not the only medical journal available to East African medical profession. Colonial medical departments gradually developed small libraries stocking relevant books and journals that allowed doctors to keep abreast of major international medical developments.¹³⁴ Journals were sometimes distributed through the central secretariat to MOs in outstations and, so far as geographical restrictions allowed, an informal culture of book and periodical swapping existed between doctors.¹³⁵ Indeed, intellectual isolation sometimes made colonial doctors all the more conscious of the need for access to contemporary medical literature.¹³⁶ About half of the monthly circulation of the *Sleeping Sickness Bulletin* went to doctors in Africa,¹³⁷ and many MOs used their periods of home leave as important opportunities to refresh their professional knowledge and gain supplementary qualifications.¹³⁸

In so far as homogeneity of medical beliefs can be determined as a unifying force, the evidence suggests that pre-World War Two MOs found themselves in an unusual situation. On one hand, they identified strongly with the contemporary medical profession of which they were a part; while on the other, they were significantly distanced from it, both physically and mentally. The establishment of the *KMJ* and of local branches of the BMA show that successful attempts were made to nurture feelings of colonial medical belonging, but doctors nevertheless found themselves both socially and professionally in a much freer space than they were likely to have experienced back home. As Driver has argued in the case of field experiences of early geographers, doctors found themselves—in terms of their daily work and intellectual development—in a position that was characterised by very little outside interference.¹³⁹ This meant that MOs often embodied more diffuse ideas than may have been acceptable back home. A curious situation developed with

¹³⁴ Eg, 69 professional journals were listed as being regularly taken in Kenya in 1929 KNA/MOH/1/10274 'Medical Journals for Staff', 1928/9

¹³⁵ KNA/MOH/1/402 'Distribution of Sleeping Sickness Bulletin' [n.d. c.1912]

¹³⁶ Calwell, 'Nineteen Years in the Colonial Medical Service', p.(s)16

¹³⁷ 'The Tropical Diseases Bureau', *BMJ*, i, 1912, p.1149

¹³⁸ WL/CMAC/PP/HCT/A5 Bray, *Hugh Trowell: Pioneer Nutritionist*, [Chapter 10], p.9; Charles Wilcocks also commented on the "quite high" trend amongst MOs to take supplementary qualifications. C Wilcocks, *A Tropical Doctor in Africa and London*, unpublished autobiography, Surrey, 1977, p.128

¹³⁹ Driver, *Geography Militant*, eg. p.51

doctors simultaneously aligning themselves with the modernity of modern tropical medicine, while frequently perpetuating old-fashioned medical ideas, particularly about disease causation.

Doctors' identification with modernity, especially in terms of the tropical medical specialism, was demonstrated not only in their shared tropical medical training, but also by active contribution to the field. Operating at the very heart of the field, Colonial Service doctors were among the few interpreters of the state of African health and medicine to the outside world; they were often the first to see unusual cases and the first to judge the efficacy of medical procedures. They also had access to the biggest trial group—the diseased African population — and so were able to compare and contrast treatments and theories of infection. It is clear from the high proportion of MOs who published scientific papers, that many identified themselves as tropical medical experts despite the generalist nature of their official duties.¹⁴⁰ MOs commonly mentioned their “almost limitless” access to topics for further research or investigation that were caused by the circumstances of their everyday duties.¹⁴¹ When writing their own histories, some MOs identified themselves as part of a long line of (field based) tropical medical pioneers.¹⁴²

About a fifth of all Colonial Medical Service doctors supplemented their qualifications while on home leave, frequently acquiring MDs based on research gathered locally. As most MOs were employed as clinical generalists, their more specific research interests arose out of the circumstances of their job; for example, involvement in a particular disease survey, participation in the work of a local laboratory, or simply a brief from senior officers to work in a particular area of tropical medicine.¹⁴³ This research was sometimes recognised internationally: a

¹⁴⁰ A glance at the indices of the *KEAMJ* of the period will reveal an extremely high number of contributions from MOs.

¹⁴¹ RHL/MSS.Afr.s.1872/82 Hunter, ‘Detailed Memorandum’, p.12; this was echoed by Farnworth Anderson RHL/MSS.Afr.s.1653, Anderson, *Reminiscences*, Book I, p.58

¹⁴² HJO'D Burke Gaffney, ‘Forefathers of Tropical Medicine’, *EAMJ*, 10, 1933–4, pp.100–114; WD Foster, ‘Robert Moffat and the Beginnings of the Government Medical Service in Uganda’, *MH*, 13, 1969, pp.237–50

¹⁴³ Charles Wilcocks took an MD based on his research into TB started during his colonial medical career as a port HO in Dar Es Salaam. Wilcocks, *Tropical Doctor*, p.43; Hugh Calwell admitted that his posting on sleeping sickness duty in 1931 to the Western Province of Tanzania fortuitously “opened a new and long chapter in my career”. He was to later take his MD on the influence of sleeping sickness on the

number of MOs in Kenya, Tanzania and Uganda were awarded the prestigious North Persian Forces Memorial Medal. This award was given for the best piece of original work in tropical medicine for the year and holders included many officers employed in the EAMS: William Hood Dye (1924 and 1927); Farnworth Anderson (1930); Neil McLean (1931); Henry Burke-Gaffney (1932) and Arthur Forbes Brown (1935).¹⁴⁴ Clearly, despite a scarcity of research facilities and a lack of access to metropolitan knowledge, many MOs had worthwhile professional information to impart.¹⁴⁵ This is also indicated by the large number who continued their tropical medical interests in subsequent careers, after retirement from the Colonial Service.¹⁴⁶

Intriguingly, despite these prevalent associations with modernity, colonial medical beliefs often also incorporated a decidedly more old fashioned approach to tropical health. While professing allegiance to the new scientific thinking did not seem to affect many doctors tenaciously adhered to traditional notions; particularly the belief that there was something inherent in the tropical climate and lifestyle that could exert a pernicious long-term effect on Europeans.¹⁴⁷ These views were becoming increasingly untenable in the UK, but right until the late 1930s, medical debate about health in Africa still regularly assumed (and actively engaged with) ideas

pathology of the brain, a suggestion from his experienced colleague, George Maclean. Calwell, 'Nineteen Years in the Colonial Medical Service', pp.(s)5-6

¹⁴⁴ There is no space here to mention all the individual contributions made by East African doctors, although Appendix 5 does give some indication of main areas of expertise.

¹⁴⁵ It took some MOs some time to contribute to the field through publications. For example Cyril Donnison did not publish his book *Civilization and Disease* (1937), which stemmed directly from his medical observations while in Kenya, until nearly a decade after his return to the UK. 'Cyril Donnison', *BMJ*, i, 1958, p.463

¹⁴⁶ The examples are numerous, some include: Arthur Bagshawe who became the first Director of the Sleeping Sickness Bureau (later to become the Bureau of Hygiene and Tropical Diseases), where he worked for 26 years. He also became the editor of the *Tropical Diseases Bulletin*, and the *Bulletin of Hygiene*; Henry Burke-Gaffney who became Assistant Director of the Bureau of Hygiene and Tropical Diseases in London, becoming its Director in 1961–68; James Corson on leaving Africa went to work for the Bureau of Hygiene and Tropical Diseases, where he remained until 1946; Claud Cole went on to be consultant physician to the Hospital for Tropical Diseases, London as well as consulting physician to the CO, the Crown Agents and the Overseas Development Administration; Percy Garnham went on to become first a reader in Medical Parasitology at the LSH&TM (1947–51) and then a Professor and Director of the Department (1952–68); Ronald Heisch was appointed on his retirement from Kenya, Senior Lecturer in the department of Parasitology at the LSH&TM.

¹⁴⁷ For more on this long tradition see KO Kupperman, 'Fear of Hot Climates in the Anglo-American Experience', *WMQ*, 1984, 41, pp.213–40; A Wear, 'Perceptions of Health and New Environments in the Early English Settlement of North America: Ideals and Reality' in *The Great Maritime Discoveries and World Health: Proceedings of the First International Congress on the Great Maritime Discoveries and World Health*, Lisbon, 1991, pp.273–8

about health and its relationship to climate.¹⁴⁸ There seemed to be no internal contradiction in most people's minds between these two ways of thinking about the world: indeed, some biomedical explanations seemed to fit quite naturally with earlier models. Theories that firmly situated themselves with the new objective science, implicitly still relied upon a generalised idea of Africa and its peoples as being inherently pathological. The nature of these associations changed as the period progressed. By the 1920s and 1930s, colonial attitudes had begun to re-orientate towards public health education, and ideas of civic responsibility, rather than continuing notions of Africa being inherently disease-provoking. It was felt that, with better education and training, Africans could learn to help themselves towards better health. Importantly, however, this idea was still based on colonialist assumptions that felt no especial need to take seriously traditional African medical practices, and did very little to research into medical techniques that might be more culturally applicable to the African tradition. It was naturally assumed that the western medical approach was the best and most universally desirable medical tradition.¹⁴⁹ As has been highlighted by Jock McCulloch in his examination of the ethno-psychiatric thinking that emanated from the African continent, almost irrespective of which psychiatric theory individual psychiatrists adopted, psychiatric analysis of the African shared important far-reaching assumptions based on the central 'childlikeness' and cognitive inferiority of the African. One of the things that McCulloch finds notable — and further supports the argument for the homogeneity of professional colonial medical ideas — is that, although there were few psychiatrists working in Africa during the 1930s onwards and although there was very little contact between them, their views were remarkably coincident and demonstrated striking uniformity.¹⁵⁰

¹⁴⁸ 'Editorial', [Effects of the Climate on the Human Constitution], *K EAMJ*, 8, 1931–2, p.331; DV Latham, 'The White Man in East Africa' *EAMJ*, 9, 1932–3, pp.276–82; M McKinnon, 'Medical Aspects of White Settlement in Kenya', *EAMJ*, 11, 1934–5, pp.376–94; 'Tropical Neurasthenia', *EAMJ*, 12, 1935–6, pp.28–9; A Walter, 'Climate and White Settlement in the East African Highlands', *EAMJ*, 11, 1934–5, pp.210–25

¹⁴⁹ This unified perspective of MOs is an interesting contrast to an argument presented by Kuklick. She concluded that the successful administrative officer was someone who held an "ideological dedication to the conservation of African tradition", Kuklick, *The Imperial Bureaucrat*, p.43

¹⁵⁰ J McCulloch, *Colonial Psychiatry and 'The African Mind'*, Cambridge, 1995, p.105

The colonies provided an important, yet isolated space for doctors to work. The limited facilities and distance from central control, allowed medicine to develop along independent lines and put Colonial MOs in an intermediary world between tradition and modernity. Yet, whatever the ambiguities expressed in the colonial situation, it is clear that the official line promulgated by colonial governing bodies, was to associate the career with active participation in tropical medical research. Although before the 1930s systematic investment in locally based research was negligible, it is clear that the intention to involve MOs had been there since the very beginning of the period. As early as 1897 one of the first recommendations made between Manson and Chamberlain was that MOs were to be encouraged to write special papers on tropical diseases that they had encountered, which were to be appended to the annual medical reports of each colony.¹⁵¹ In 1912 the standing orders of the Uganda Medical Department made this hope explicit. The written regulations expressed the formal expectation that all MOs would take “a specially active interest in the investigation, treatment and prevention of such diseases as are endemic, epidemic or unduly prevalent in the Uganda Protectorate”. It went on to stress the importance of individuals making collections and bionomic studies of insects that were possibly implicated in the transmission of disease to man.¹⁵² As the Colonial Medical Service grew (along with tropical medicine), the emphasis put upon developing specialist interests among its employees also expanded. By the 1920s the CO was pushing a recruitment line that a Service career might make a tangible difference to doctors’ research ambitions.¹⁵³ It was emphasised that individuals would have more opportunities to undertake pioneering research, with more professional independence than was normally available in the home environment.¹⁵⁴

One additional point indicates an important element of the specifically medical aspects of this group’s identity: the way MOs differentiated themselves from

¹⁵¹ Manson-Bahr, *History of the School of Tropical Medicine in London*, p.29

¹⁵² FCO/14634 ‘Organisation of the Medical and Sanitary Services in the British Colonies: Replies to Circular Despatch: 1st February 1913’, *Standing Orders for the Medical Department* [Uganda], Government Press, 1912, p.1

¹⁵³ Balfour, ‘Vistas and Visions’, *Colonial Service Recruitment No.3, Information Regarding the Colonial Medical Service*, 1935, p.11; see also ‘Colonial Medical Service’, *BMJ*, ii, 1938, pp.546–8, p.546

¹⁵⁴ AGH Smart, ‘An Impression of Life in the Colonial Medical Service’, *St. THG*, 37, 1939, pp.123–6, p.123; Balfour, ‘Vistas and Visions’

other groups of Colonial Service workers. Despite the emphasis on working together “with as little friction as possible” with officials in other departments,¹⁵⁵ MOs clearly did distinguish themselves from other Colonial Service members, including some within their own department. Sanitary Inspectors, for example, felt particularly discriminated against by their medically qualified colleagues, so much so that they complained in 1937 that in East Africa they were “regarded as in a lower social sphere than other officers and were classed with Engine Drivers and Railway Foremen; they weren’t admitted to the best social clubs, invited to dinner parties or generally made welcome”.¹⁵⁶ Owing to the nature of their duties, MOs held a certain amount of power in some spheres of Colonial Service activity. They represented the principal guardians of all government employees’ health, and as part of their official rôle found themselves drafted in as experts when the central colonial government had to make certain personnel decisions. MOs issued health certificates that were often the sole basis for the decision whether officers were invalided out of the Colonial Service. Doctors also had an important say in which officials were most physiologically or psychologically ready for leave. This power within the community, meant that “the lordly DC could not always ride roughshod over the humble MO”; indeed members of the other Colonial Services needed to keep MOs onside in the eventuality that they needed a medical certificate for themselves or their families. As John Carman tellingly remembered, the doctor could “usually find a good excuse” for withholding a medical certificate if he so wanted.¹⁵⁷

The ways in which Colonial MOs identified with their membership of the medical profession did not necessarily override their identification with other aspects of their collective group culture, but rather it was a vital component of their complex group identity. Community spirit between colonials was also fostered through their collective attitudes and behaviour; these sometimes went beyond affiliations determined by their profession or their shared involvement in governmental service. Some of the attitudes that MOs espoused were expressions of a group culture of

¹⁵⁵ FCO/14634 ‘Organisation of the Medical and Sanitary Services in the British Colonies’, p.1

¹⁵⁶ It is unlikely that they would have been treated differently at home. PRO/850/109/13 ‘Sanitary Inspectors and Sanitary Superintendents: Conditions of Service’. 19/11/1937

¹⁵⁷ Carman, *Medical History of Kenya*, p.41

whiteness, one that bound people together through shared allegiance to certain aspects of British culture.

United by Attitudes and Conduct

Colonial behaviour conformed to certain conventions. These were expressed in the way officers related to the people they ruled, the accepted modes of conduct that were required between fellow European colonials, their recreational interests, their conceptions of family life and their ideas about their new tropical home. Although individuals necessarily held different opinions, the evidence nevertheless presents a striking uniformity of attitude.

All colonials, whether settlers, missionaries or government officials, were ultimately bound together by their skin colour. This firmly identified them as members of the ruling class with a dominant socio-political rôle as officials, overseers or converters. Mutual racial identification, however, had particularly strong connotations within the medical sphere since it was often through the language of medicine that racial segregation was justified and African people were described in (inferior) contrast to their 'civilised' rulers.¹⁵⁸

Unlike the Indian Civil and Medical Services, all Colonial Officers had to be British either by birth or naturalisation (see pp.51–2). Justification for the debarment of indigenous people was often articulated in rather general terms: they did not have the 'character' for effective public service. Africans had no written culture, and their society was arranged in a sufficiently dissimilar way to European society for British rulers to assume a lack of fit between the two systems. It was felt that, until a point where Africans were trained in western models of governance and social policy, they were unable effectively to participate in the government process—except at a very low level. "Personality and character" of colonial officers were presented as essential traits "for proper handling of the natives".¹⁵⁹

¹⁵⁸ There was a racial hierarchy, with the majority of Africans at the bottom, the Baganda people a little higher up (because of their membership of an ancient African kingdom), then Indians, then Europeans at the top.

¹⁵⁹ Quoted in Marshall, 'The British Experience of Imperial Rule' p.4

The racial policy of the CO was so strong during this period that even those with medical qualifications registrable in the UK were sidelined to subordinate posts within the Medical Department if they were not of Caucasian extraction. An Indian doctor, Sakharam Ramachandra Bhagwat, was listed in the *Medical Directory* as working as an Assistant Surgeon in the Uganda Medical Department between 1913–20. Yet he possessed medical qualifications equivalent to his higher-ranking white contemporaries; he received his BSc at Bombay (1902), LRCP, LRCS (Edinburgh, 1908) and LRFPS (Glasgow, 1908) and had written scientific articles including one published in the *BMJ*.¹⁶⁰ Although he was a registered licensed private practitioner in Uganda, presumably working for the local Asian population, he was only given a subordinate position in the Colonial Medical Service.¹⁶¹ In contrast, a white doctor, Alexander Lester, who had received his medical qualifications (MB, BS) in Bombay, had a long career as a member of the Colonial Medical Service in Tanzania and Uganda from 1924 onwards despite having no British qualifications.

Doctors naturally subscribed to certain ubiquitous ideas about race that characterised white attitudes in general, although the odd exception can be found.¹⁶² Typically, “[t]here was little or no social intermingling between the different races” in the period before the Second World War.¹⁶³ In contrast to West Africa, which developed a less rigid demarcation between Africans and Europeans, because of the emerging British-educated African elite, East African society was resolutely segregationist in its approach to social, political and economic affairs. Africans were rarely entertained in European homes, and if friendships developed between the races it was invariably within the confines of a master-servant relationship.¹⁶⁴ Colonial Officers in particular, with their rôle intimately connected to governance, had little

¹⁶⁰ SR Bhagwat ‘Rupture of Pleura Without Fracture of Ribs Caused by a Buffalo’, *BMJ*, i, 1913, p.168

¹⁶¹ PRO/CO/612/3 *UP Gov. Gaz.*, 15/07/1913, p.296

¹⁶² RHL/MSS.Afr.s.1872/75 Robert Samuel Hennessey, ‘Learning About Disease in Uganda: 1929–44 and 1949–55’, 1983, p.8

¹⁶³ RHL/MSS.Afr.s.1872/16 A Boase (compiled, RM Boase), ‘Notes on Experiences in Colonial Medical Service in Uganda, 1924–56’, 14/02/1983, p.2. Racial fears were furthered through worries about Africans beings infected with venereal disease. See P Levine ‘Public Health, Venereal Disease and Colonial Medicine in the Later Nineteenth Century’ and M Tuck, ‘Venereal Disease, Sexuality and Society in Uganda’ in R Davidson and L Hall, (eds), *Sex, Sin and Suffering: Venereal Disease and European Society Since 1870*, 2001, pp.160–72, pp.191–204

¹⁶⁴ RHL/MSS.Afr.s.1872/82 Hunter, ‘Detailed Memorandum’, p.23

scope, compared, for example, to missionaries, to transgress the unspoken social boundaries.¹⁶⁵

One of the things that physically delineated Europeans from their African counterparts was the inequity of facilities established by the colonial governments for different racial groups. While hospitals built for Africans were in a poor state, the European hospitals received higher subsidies and greater attention was paid to their facilities. Town planning schemes also prioritised European enclaves rather than native quarters; as Julian Huxley remarked on his trip to Kenya in 1929 “[t]he Europeans have as much air, view and space as they need; but behind this attractive façade is a slum”.¹⁶⁶ The specifically medical demarcation of the racial ‘other’ has been the subject of much medical historical study.¹⁶⁷ Popular associations came to surround the indigenous populations, identifying them with the principal sites of disease and characterising them as the location of unwholesome behaviour. The African people came to represent the inverse of the values and behaviour that the white community supposedly represented (“Africa is whatever the British are not”).¹⁶⁸ Although conceptions of the African are not the subject of this discussion, it is nevertheless worth acknowledging that the colonial identity was partially constructed in direct opposition to many accepted collective ideas of mass African identity. To the modern eye, these categorisations embody crude and unfair generalisations. At the time they acted as a critical opposite against which the white community could define itself. When social anxieties developed in Kenya over black men raping or molesting white women (the ‘black peril’), active debate and coverage of racial issues united the white community through their shared perception of the risks to which the African population exposed them.¹⁶⁹ It was an entirely logical reaction, perhaps, to categorise what was culturally, scientifically and epistemologically confusing as the

¹⁶⁵ RHL/MSS.Afr.s.1872/153a Williams, ‘Detailed Memoranda’, p.10

¹⁶⁶ Huxley, *Africa View*, p.25

¹⁶⁷ Most prominently, Vaughan, *Curing Their Ills*

¹⁶⁸ Hammond and Jablow, *The Africa That Never Was*, p.183

¹⁶⁹ HB Hinde, ‘The ‘Black Peril’ in British East Africa: A Frank Talk to Women Settlers’, *Emp.Rev.*, 1921, pp.193–200

inverse of what the colonisers saw themselves to represent.¹⁷⁰ Beliefs were often so embedded that their supporters did not make a conscious decision to subscribe to them. Colonial society in this pre-1939 period had many rigid ideas about ‘proper’ collective behaviour and it was unquestioningly assumed that the colonisers and the colonised would not mingle (see below).

Aside from differences of skin colour, there were differences in social status that affected the way colonials behaved and informed their collective attitudes. As Terence Ranger has pointed out, even white agriculturists in Africa saw themselves more as upper-class settler farmers than peasants.¹⁷¹ Perhaps precisely because equivalent class ideals were becoming increasingly out-moded in Britain, they were increasingly celebrated and magnified in the colonial setting.¹⁷² In 1939, Charles Jeffries could still describe the career as “a Service in which you are treated as a gentleman by gentlemen”.¹⁷³ In general these idealised values referred back to a rural aristocratic model rather than to any more modern conceptions of the urban entrepreneurial spirit and, even if anachronistic, they were thought to be attractive features of colonial society. The colonies symbolised the last bastion of an old British social system. This image certainly influenced attitudes towards Colonial Service recruitment positively, but it also informed opinion of those resident within the colonies — as one old Kenyan colonial told another “[w]hy should I retire to England? In this country I am somebody; in England I would only be a number on a door”.¹⁷⁴

This is not to say that there were no criticisms of this image. Opinions were voiced that, Empire was too intrinsically conservative and resistant to change or self-reflection. All government employees had to slot ideologically into an established system, with a primary objective to master “their section of the machine”, a notion

¹⁷⁰ A good summary of these ideas can be found in W Anderson, ‘The Third-World Body,’ in R Cooter and J Pickstone (eds.), *Medicine in the Twentieth Century*, Amsterdam, 2000, pp.235–45

¹⁷¹ Ranger, ‘The Invention of Tradition in Colonial Africa’, p.213, p.221

¹⁷² Argued by Cannadine *Ornamentalism*, esp. p.66, p. 122

¹⁷³ Quoted without reference in Jeffries, *Partners For Progress*, p.90

¹⁷⁴ A Johansen, *The Kenya I Knew, 1904–1963*, p.48 quoted in E Trzebinski, *The Kenya Pioneers: the Frontiersmen of an Adopted Land*, 1991 [1985], pp.103–4

that, while it offered some autonomy of action, also left very little room for innovation or flair.¹⁷⁵ Other critics felt that the overwhelming public school ethos contributed to the development of inward looking colonial type “which is innocently, but none the less insolently, Narcissistic—it takes itself for pattern and cannot trouble to see that any other types could be really admirable”.¹⁷⁶ These proved to be resilient themes in later criticisms of the Colonial Service; even when describing administrative officers in the 1960s, Colonial Service commentator Robert Heussler lamented that “today’s administrators...perfect and transfer more than they design and build”.¹⁷⁷

Nevertheless, the conservative ethos of the socially privileged predominated. Everything that was possible was done to make the colonial setting a place that physically, socially and culturally conjured up home. Even in the smallest stations, British traditions were upheld. The monarch’s birthday was celebrated, British public holidays were adhered to and ceremonies were put on to welcome governors and visiting dignitaries. Caledonian and St. George’s dinners were regularly held from the turn of the century, as well as the Old Etonian dinner held on 4 June each year at the Norfolk Hotel, opened in 1904 and (tellingly) alleged to be the “Claridge’s of Nairobi”.¹⁷⁸ The pages of the contemporary Government Gazettes of each respective territory reveal the type of occasions organised by these ‘micro’ British communities.¹⁷⁹ Announcements of sporting events, dinner dances, race-meetings, agricultural and horticultural shows all point towards the reproduction of middle and upper-middle class Britain.¹⁸⁰

Naturally enough, the main social centres were the large towns. European Clubs were established in Nairobi, Entebbe and Dar Es Salaam, and became important sites of social mingling. As prominent members of the European

¹⁷⁵ Davis, *Microcosm of Empire*, pp.48–9

¹⁷⁶ Huxley, *Africa View*, p.34

¹⁷⁷ R Heussler, ‘An American Looks at the Colonial Service’, *New Commonwealth*, 1960, pp.418–20, p.419

¹⁷⁸ Trzebinski, *Kenya Pioneers*, p.101, p.104. The hotel still plays on this colonial image today.

¹⁷⁹ Indeed the Gazettes were an important means of keeping widely dispersed communities mutually informed. Calwell, ‘Nineteen Years in the Colonial Medical Service’, p.(s)13

¹⁸⁰ References can be frequently found in the Government Gazettes for all three territories.

community, MOs commonly met there and used them for social gatherings.¹⁸¹ Other groups also developed around churches, the YMCA, the Rotary club and voluntary organisations.¹⁸² Even those colonials posted to more isolated stations were encouraged to build a home from home; advice existed on how to keep an English country garden, and the small communities that formed around *bomas* held their own local events and dinner parties.¹⁸³ As Fuller has argued, one of the primary undertakings of the British administration was to “institute the comforts of home, to establish a visual and social environment which resembled England as much as possible in order to provide a sense of security and demonstration of English ‘civilization’”.¹⁸⁴ One of the ways this was done by the CO itself was increasingly to emphasise the social benefits of colonial life.¹⁸⁵ What the location lacked in art galleries and theatre, it made up for in abundance of sporting events, social opportunities and wildlife.¹⁸⁶ In 1911 Nairobi was said to be a town that was “one of the best equipped with pastimes in the world”, with opportunities for dances, films, sports and clubs.¹⁸⁷ Dar Es Salaam was described as cheap to live in while possessing a cinema and two European clubs; Tabora (Tanzania) was said to have a good lending library, a decent club, and held popular film events once a fortnight.¹⁸⁸ One of the most evocative images of relaxed civility, however, has to be that given by Frederick Treves, describing his trip to Uganda around 1910:

Entebbe is the administrative capital of Uganda. It is as unlike a capital as any place can well be, while as for administration it must be that kind which is associated with a deckchair, a shady verandah, the chink of ice in a glass, and the curling smoke of a cigar. Entebbe, as being the prettiest and most charming town on the lake, would seem to be concerned more with her appearances than with the cares of

¹⁸¹ Indeed, Cliff Braimbridge’s presence in the Nairobi club was described as being ‘large’ in one of his obituaries. ‘Clifford Braimbridge’, *EAMJ*, 41, 1964, p.31

¹⁸² T.F.V. Buxton, ‘A Social Effort in East Africa’, *JRAS*, 39, 1911, pp.342–4; RHL/MSS.Afr.s.1872/33 Cole, ‘Memorandum on Experiences’; this point is also made in Kennedy, *Islands of White*, p.189

¹⁸³ Lord Cranworth, *A Colony in the Making. Or Sport and Profit in British East Africa*, 1912, p.90

¹⁸⁴ T Fuller, ‘British Images and Attitudes in Colonial Uganda’, *Historian*, 38, 1976, pp.305–18, p.306

¹⁸⁵ *Colonial Service Recruitment No.3*, pp.29–31, p.36

¹⁸⁶ Jeffries, *Partners For Progress*, p.158

¹⁸⁷ Lord Cranworth, ‘The Public School Boy in East Africa’, *Nat.Rev.*, 336, 1911, pp.992–1000, p.996

¹⁸⁸ Calwell, ‘Nineteen Years in the Colonial Medical Service’, p.(s)5, pp.(s)23–4

state....Entebbe, indeed, gives the impression of being a place of leisure, a summer lake resort where no more business is undertaken than is absolutely necessary.¹⁸⁹

Although facilities clearly got better once an administrative infrastructure was established in the second half of the period, from the earliest colonial times attempts were made by resident Europeans to bring to tropical Africa the better features of home. Sport was one of the most important aspects of British life to be transported to the colonies.¹⁹⁰ Indeed, this became a notably important part of the colonial identity and many MOs were praised for their outstanding sporting abilities.¹⁹¹ Descriptions of colonial life invariably invoked sporting opportunities as one of the most dynamic features of colonial life.¹⁹²

Another way that Britishness was expressed was through the strict codes of social behaviour that developed in the colonial locations. These naturally enough mirrored conventions back home, but the stress put upon formality in the bush was remarkably persistent, despite its obvious inappropriateness in a tropical climate with dispersed European society. Dressing for dinner, for example, was a standard ritual “in the most isolated outposts as well as its social centers[sic.], for parties or when dining alone”, and would have also acted as a visual marker of distinctions of race, gender and social rank.¹⁹³ A colonial medical wife described the three stages that comprised the local social etiquette for greeting new *boma* arrivals: firstly ‘calling’ (usually just leaving a calling card), then the sundowner (an evening drink) and lastly, the dinner invitation. The dinner would be a formal occasion with evening dress, seating plans organised by rank, and the best silver, glass and china the hostess could

¹⁸⁹ F Treves, *Uganda for a Holiday*, 1910, pp.204–5

¹⁹⁰ Mangan, *The Games Ethic and Imperialism*; JA Mangan (ed.), *The Cultural Bond: Sport, Empire, Society*, 1992

¹⁹¹ ‘Clifford Braimbridge, *Lancet*, i, 1964, p.279; ‘Edward Clarence’, *EAMJ*, 14, 1937–8, pp.138–9, p.139; ‘Henry Speldewinde de Boer’, *BMJ*, i, 1957, pp.1533–4, p.1533; ‘Aubrey Hodges’, *EAMJ*, 23, 1946, pp.289–90, p.289; ‘Claude Marshall’, *EAMJ*, 34, 1957, p.280; ‘Arthur Williams’, *BMJ*, i, 1958, p.1421; ‘Roland Dowdeswell’, *BMJ*, ii, 1956, p.305.

¹⁹² Cranworth, *Colony in the Making*, pp.324–42; *Colonial Service Recruitment*, No.3, p.36

¹⁹³ H Callaway, ‘Dressing for Dinner in the Bush: Rituals of Self-Definition and British Imperial Authority’ in R Barnes and JB Eicher (eds.), *Dress and Gender: Making and Meaning in Cultural Contexts*, Berg, 1992, pp.232–47, p.233

muster.¹⁹⁴ It was generally accepted that new colonial arrivals, including MOs, would call upon their seniors very soon after their arrival in a colony.¹⁹⁵

Colonial life in the thirties was still governed by inflexible rules. Africa was probably never as rigid as India, nevertheless the newcomer had to learn a code and abide by it. On arrival the mysteries of calling were first performed, especially in the smaller stations. You called on your seniors while your equals and juniors called on you. This involved the whole paraphernalia of hats, gloves, and stockings, not to mention visiting cards.¹⁹⁶

To some MOs this emphasis upon protocol seemed decidedly old-fashioned. Hunter and his wife, who arrived in Uganda during the late 1930s, found themselves immersed in a world of social etiquette to which they had not been used at home: “[w]e were not used to the full ritual of calling cards, visitors-books with P.P.e. entries etc. and dressing for dinner so regularly; sitting by strict order of precedence at dinner parties”.¹⁹⁷ Margaret Wilson, characterful wife of MO Bagster Wilson, and doctor in her own right, described in her Tanzanian diary their social calendar in June 1933. It provides an impressive example of a colonial schedule:

Last Friday we were hard at it in the Lab. till 8pm...Sat. am the same. Then D[onald Bagster] and I went for a Swim. Returned and Nicholls from Amani came to have a drink. Rushed into evening clothes. People arrived for dinner, grapefruit, kidney soup, fillet of beef, golden cream, cheese fondue. Then off to dance at the Club and stayed until 2.30am when my feet refused to function anymore, ending up with a wild Polka with D. Went to Gombero in the Afternoon. Walked for 3 hours before breakfast and saw three buffalo, wart hog, water buck, duiker and steenbok. We are going again next week with our rifles.¹⁹⁸

Clothing was an obvious way in which social principles were visually upheld. Women were particularly advised to dress appropriately.¹⁹⁹ One piece of sartorial

¹⁹⁴ Trowell, *African Tapestry*, pp.22–3

¹⁹⁵ RHL/MSS.Afr.s.1653, Anderson, *Reminiscences*, Book I, p.19

¹⁹⁶ Trowell, *African Tapestry*, p.21; See also WL/CMAC/PP/HCT/A5 Bray, *Hugh Trowell: Pioneer Nutritionist*, [Chapter 4], p.5

¹⁹⁷ RHL/MSS.Afr.s.1872/82 Hunter, ‘Detailed Memorandum’, p.4

¹⁹⁸ RHL/MSS.Afr.s.1872/162(a) M Wilson, ‘Memoirs of Service as Entomologist, Health Officer and Medical Officer in Tanganyika, 1933–63’ [n.d.]

¹⁹⁹ Although men going to East Africa were advised to take evening wear. A Field, ‘*Verb. Sap.*’ *On Going to East Africa: British Central Africa, Uganda and Zanzibar and Big Game Shooting in East Africa*, Vol. 2, 1906, p.16, p.12

advice recommended that women pack for their trip at least “two or three evening dresses of crêpe de chine, satin and velvet”.²⁰⁰ The MO wife, Mrs Bödeker, “one of those women who kept up standards despite everything”, allegedly bought with her to Kenya a “large variety of hats...trimmed with osprey and veiling to match a selection of gowns in the high fashion of the day”.²⁰¹ This was quite in keeping with expectations, even if the exigencies imposed by local circumstances meant that decorous and formal behaviour had to occasionally be put to one side, for example while on a medical safari, or trekking through the bush. Dressing for dinner meant that people were always coming back to their civilised roots by the evening. Keeping up standards was, however, not just about distancing European communities from the behaviour of the natives, it was also thought to be good for morale. Women, by keeping themselves decent, were doing important work for both themselves and their husbands in terms of keeping up standards:

As for finery it is as important for your morale as for your husband's. It is all too easy, in hot countries, to become used to faded cottons, dim linens of indeterminate colour and pattern and crumpled voiles. First thing you know, you are wearing them once too often, and that is the beginning of the Sad Story of the Slut. If there is any doubt, there is no doubt. Into the basket!²⁰²

It was imperative for Officers' careers that they subscribed to these and other common ideas of propriety. Social gatherings were an important chance to network and much of the valuable experience officers gained was “socially effected, at dinner tables or at clubs”.²⁰³ The sundowner particularly was seen as a chance for younger officers to be introduced to the codes of conduct within colonial life.²⁰⁴ Clearly some MOs found these social requirements rather trying — Farnworth Anderson complained of the many unspoken directives such as “regulation dress” and “regulation refreshment” (whisky) at sundowner time — but in general officers

²⁰⁰ Lady Cranworth, ‘Hints for a Woman in British East Africa’ in Cranworth, *Colony in the Making*, pp.84–92, p.87

²⁰¹ Trzebinski, *Kenya Pioneers*, p.10

²⁰² E Bradley, *Dearest Priscilla: Letters to the Wife of a Colonial Civil Servant*, 1950, p.37

²⁰³ Interview: Heussler with HE Newnham, 06/08/1959; Letter: Newnham to Heussler 02/09/1959 quoted in Heussler, *Yesterday's Rulers*, pp.42–3

²⁰⁴ Kennedy, *Islands of White*, p.137

acknowledged the advantages of conformity more than they resisted it, and even came to enjoy the social aspects of their work.²⁰⁵

After 1919, when European women (usually in their capacity as wives) increasingly became a feature of colonial life, one of the ways that colonials made their new environment more like home was through instituting 'normal' rituals of British family life. The replication of middle-England was so successful, that Julian Huxley evocatively described Kenya in 1929 as "suburbia unrestrained".²⁰⁶ The first European marriage in Nairobi is said to have been that of an MO, Clare Wiggins, in 1904.²⁰⁷ Gradually it became more common for officers to marry in Africa, as did both Raymond Barrett (in Uganda) and Bagster Wilson (in Tanzania) in the early 1930s.²⁰⁸ Many Colonial Officers' wives had children in the colonies, and many children were schooled there, usually in Kenya, which had the best schooling facilities in East Africa.²⁰⁹

One widely perceived corollary of the increased presence of women in the colonial location was an erosion of relations between Europeans and Africans. Before the arrival of European women, concubinage was recognised (if unmentioned) as one of the perks of the job.²¹⁰ Indeed it was so overt that the government felt impelled to issue a circular directive in 1909 reminding officers of the inappropriateness of this behaviour.²¹¹ The arrival of European women has been regarded by many historians as marking a period of increased tensions between white and black communities with the significant hardening of racial boundaries.²¹² These

²⁰⁵ RHL/MSS.Afr.s.1653, Anderson, *Reminiscences*, Book I, p.27

²⁰⁶ Huxley, *Africa View*, p.213

²⁰⁷ Wiggins, 'Early Days in British East Africa and Uganda', p.708

²⁰⁸ RHL/MSS.Afr.s.1872/9 Barrett, 'Memorandum on Experiences', p.6; RHL/MSS.Afr.s.1872/162(a) Wilson, 'Memoirs of Service'

²⁰⁹ Eg, wives of Drs Boase, Trowell, Hunter.

²¹⁰ A McClintock, *Imperial Leather: Race, Gender and Sexuality in the Colonial Conquest*, 1995

²¹¹ PRO/CO/850/47/4 Lord Crewe, Confidential Circular, 11/01/1909; The drastic change in official attitudes to concubinage that this marked is discussed in Ronald Hyam, 'Concubinage and the Colonial Service: The Crewe Circular (1909)', *JICH*, 14, 1986, pp.170-86

²¹² A Stoler, 'Making Empire Respectable: The Politics of Race and Sexual Morality in 20th-Century Colonial Cultures' in J Breman, P de Rooy, A Stoler and WF Wertheim (eds.), *Imperial Monkey Business: Racial Supremacy in Social Darwinist Theory and Colonial Practice*, Amsterdam, 1990, pp.35-70; Kuklick, *The Imperial Bureaucrat*, p.122; Hinde, 'The "Black Peril"', p.195

women brought with them new moral codes and an emphasis on etiquette and decorum; they instituted home-grown standards and upheld the moral tone.

Yet vitally, among all this ritual and archetypical British behaviour, lay continually reiterated expressions of difference. Difference was what ultimately made the colonial experience exciting and helped make up for perceived deficiencies in terms of employment or pay. It aligned officers with an evocative history of travel and exploration and made them living examples of an imperial genre of adventure within popular literature and (in the later period) film. New recruits arrived “bursting with zeal to start this Sanders of the River business” and the archetype continued to inform the way the group’s identity was expressed.²¹³ There was no necessary internal contradiction in this double embracing of both similarity and difference. On one hand, colonial officials expressed their identity through reference to their shared roots, while on the other, they stood together because of their shared place-specific experiences. Colonial African identity embraced both historic ideas of adventure and embedded ideas of British conduct and decorum; as one contemporary commentator put it, it combined expressions of “individual spirit and enterprise” with a “desire to establish British culture and civilisation”.²¹⁴ Even exaggerated Britishness made Africa a different enclave.²¹⁵

One of the most obvious things that made colonial life distinctive was the climate. This necessitated the adoption of various health regimens to ensure salubrity. These routines were endorsed by the medical profession and were seen as essential to a successful colonial life. Much health advice centred on the ill effects of the sun. Wearing spine-pads, cholera belts or topees (sun helmets) was recommended. Regimens involved drinking alcohol only after sun down, bathing at certain times of the day and avoiding certain foods. As Lord Cranworth advised those contemplating a life in Kenya: “although a hairy chest peeping through an unbuttoned shirt is picturesque and gives the air of a pioneer, in reality the less surface exposed to the sun the better”. Above all Europeans in the East African tropical world were advised to

²¹³ Mitchell, ‘Forty Years Back’ p.280

²¹⁴ Davis, *Microcosm of Empire*, p.2

²¹⁵ Driver has argued conduct was as important as professional work in informing group identity. Driver, *Geography Militant*, pp.63–4

adhere to the maxim “keep the spirits up, the bowels open, and wear flannel next to the skin”.²¹⁶

Many contemporary descriptions expressed this combination of the strangely familiar, yet ultimately unique, nature of the colonial experience. Calwell remembered how the house he had in Ushirombo, Tanzania, although infested with white ants, with only petrol boxes for bookcases, a grass roof and a pit latrine, nevertheless had beautiful rose bushes planted around the verandah.²¹⁷ This in many ways was the key of colonial life; it could replicate a nostalgic vision of aristocratic land owning classes back home, while also being crucially and exotically different. The memories of Rex Surridge, who started in 1923 in the Tanzanian CAS, illustrate the contrast aptly; on walking through his *boma* for the first time he found:

...carnations, roses and violets in bloom, a lovely running stream and a glorious climate. So good, indeed, that many Europeans and Asians had settled in the area; there was a country club with golf course and tennis courts, and even a few horses—plus the odd lion.²¹⁸

Big game hunting particularly seemed to sum up this difference — while conforming to a public school sporting ethos, it also was an undeniably unusual pastime for most British. It neatly encapsulated the romantic associations of African adventure and its essential difference within easily understandable terms of reference. Within East Africa, particularly, hunting was a fundamental part of the colonial identity and the majority of officers regularly participated in the sport.²¹⁹

Finally, language reflected and reinforced behaviour. It was common for Colonial Officers to learn Kiswahili, but the specific manner in which they did went far beyond the mere pragmatics of facilitating communication with the communities they ruled.²²⁰ Some officers learnt local African dialects,²²¹ but attention throughout

²¹⁶ Cranworth, *Colony in the Making*, p.17, p.20

²¹⁷ Calwell, ‘Nineteen Years in the Colonial Medical Service’, p.(s)7

²¹⁸ R Surridge, ‘Salad Days in Tanganyika’ in Kirk-Greene, *Glimpses of Empire*, pp.283–6, p.284

²¹⁹ ‘Roland Dowdeswell’, *BMJ*, ii, 1956, p.305; Mitchell, ‘Forty Years Back’, p.280; RHL/MSS.Afr.s.1782, ADP Hodges, Diaries 1898–1907, eg, 19/06/1898 – 12/09/1898

²²⁰ This was an almost universal rite of passage. Explicit references to learning Swahili include: Calwell, ‘Nineteen Years in the Colonial Medical Service’, p.(s)10; KNA/MOH/1/5409 Swahili Examination to Officers [n.d.]; Officers in Tanzania who passed the Swahili examination were regularly listed in the *TT Gov. Gaz.*

East Africa was focused upon learning Kiswahili — not least because CO terms of employment included a salary incentive (the language allowance) to those who had passed appropriate examinations.²²² This led to a situation whereby some officers took standard language examinations even though they were posted to districts where Kiswahili was not widely spoken; a smattering of Kiswahili became a marker of European colonial identity irrespective of its actual applicability.²²³ If Bernard Cohn's argument for the European interest in learning Indian languages (during the consolidation of power of the British East India Company) is followed, then this drive to take on language could be seen as a further attempt to appropriate culture in such a way as to confirm European superiority.²²⁴

In the East Africa context colonials used African language to define not only themselves, but also their relationships with indigenous people. One contemporary account described the variant used by Europeans as “kitchen Swahili”. This guide advised prospective students to descend from the “mountain heights of linguistic precision” — the best way for them to converse with the “*wa-shenzi* (backward peoples)” was to use an imprecise hybrid of language.²²⁵ Kitchen Swahili was a crude pidgin, made by stringing together various essential Swahili nouns and verbs, interspersed with English.²²⁶ It was used not only to communicate with Africans, but also to bind together European communities in a mutual code. When colonials spoke to each other they typically littered their regular speech with Kiswahili words that implied shared understanding and mutual recognition and rudimentary African language ability became an important part of a shared colonial expression. John Carmen affectionately remembered the motto he constructed with his colonial medical workmate, Cliff Braimbridge: ‘Hakuna Pesa Nyingi, Lakini Tunaona sana La

²²¹ ‘James Henry Bartlett’, *EAMJ*, 30, 1953, p.493; ‘Enrico Pietro Bayon’, *BMJ*, ii, 1952, pp.1260–1, p.1261

²²² In the CAS officers would not pass probation if they had not achieved a native language examination. Mills, ‘Methods of Appointment and Training’, p.467

²²³ RHL/MSS.Afr.s.1872/153a Williams, ‘Detailed Memoranda’, p.7

²²⁴ BS Cohn, *Colonialism and its Forms of Knowledge: The British in India*, Princeton, NJ, [1985], pp.16–56

²²⁵ E Brodhurst-Hill, *So This is Kenya!*, 1936, p.30

²²⁶ Another name for the Swahili spoken by Europeans was “Ki-Settler” (a pun on Ki-Swahili). Cook, ‘The Medical History of Uganda: Part 1’, p.74

Vie' ('we haven't got much money, but we do see life').²²⁷ The very way this phrase was conceptualised, using a hybrid of Kiswahili and French, celebrated shared educational roots (i.e. it assumed a knowledge of French) while referring also to their acquaintance with a new language derived specifically from the colonial location.

Colonials adopted certain emblematic behaviours that bound them together as a group. As well as physically converging, as often as they could, at clubs, dinner parties and sporting events, they were also bound, despite geographical distances, by uniformity of approach and attitude. There was a remarkable convergence of ideas; ones that harked back to a bygone British age while celebrating the new challenges thrown up by the colonial situation. Many of these factors were not unique to the colonial medical experience, but they did inform the identity of the group. Combined with other group loyalties, a very distinctive group identity emerged among East African colonial doctors.

* * *

Officers had to adhere to uniform conditions of Service, and they were constrained in many of their actions by the power of the CO. They were also united with other members of the medical community through their shared training and professional perspective and, riding above all these vocational affiliations, they were closely tied to the white colonial community in general. At the heart of these converging group commitments lay a tacit acceptance of the priority that had to be afforded to the local, East African, experiences.²²⁸

All these different factors demanded allegiance at different levels. If at one level colonials stood shoulder-to-shoulder in support of the imperial mission, or in support of keeping out undesirables from their community (there were protests in East Africa against Jewish immigrants, Austro-German refugees and poor whites²²⁹),

²²⁷ Carman, *Medical History of Kenya*, 1976, p.67

²²⁸ Huxley, *Africa View*, p.374

²²⁹ PRO/CO/850/120/8 Memorandum for the Colonial Office on the Employment of Refugees (Medical Practitioners), 20th September 1938. See also PRO/CO/850/144/1 Memorandum by RR Scott, Tanganyika Territory, 17th April 1939; Brodhurst-Hill, *So This is Kenya*, p.2; Trzebinski, *Kenya Pioneers*, p.111, p.134

at another level society was split into numerous localised allegiances, stemming from the affiliations that developed around the *boma*, the district, or through professional ties.²³⁰ Local loyalties were expressed in numerous ways: MOs, for example, were reprimanded for associating too closely with members of other colonial groups, even missionaries.²³¹ Settlers and Government officials were said to fall into two distinct camps, invariably in direct opposition to each other. Arthur Williams noted during his outward voyage to Africa that settlers regarded officials as “anathema”.²³² Often these rivalries were played out on sports fields through the Settler versus Official cricket, football and rugby matches that became a regular feature of colonial life. Each colonial group had its own subtle version of identity. Whether settlers, missionaries or conscript doctors, they drew upon common experiences and made distinctions between themselves and other groups.²³³ The fact that each European group, including MOs, can be reduced to common denominators of local allegiance still acknowledges the need to work within an overarching colonial identity.

MOs were a distinct sub-group working within the broader definitional frameworks of government service culture, medicine and colonialism. Of course there was no absolute homogeneity, people did speak their minds and individuals did go against convention. But, crucially, the factors of their employment and situation tended to militate against change and favoured preserving the status quo. This resulted in a preoccupation with maintaining cultural norms and the presentation of a united front, even if the group as a whole did not actually constitute one.

²³⁰ “Letters in the file addressed by two neighbouring District Officers to each other seemed to proceed not from brother officers but from states lately belligerent”, D Cameron, *My Tanganyika Service and Some Nigeria*, 1939, p.24

²³¹ Wiggins, ‘Early Days in British East Africa and Uganda’, p.701

²³² RHL/MSS.Afr.s.1872/153a Williams, ‘Detailed Memoranda’, p.3

²³³ Although, I would argue, these sub-groups were ultimately defined by their shared colonial experiences over and above individual differences. For similar tropes in a different group of doctors see JSG Blair, *The Conscript Doctors: Memories of National Service*, Durham, 2001

6. Conclusion

6.1 The Stories That Have and Have Not Been Told

This work draws together common strands within East African colonial medical careers before World War Two. It considers CO selection criteria; the motives for doctors to apply for governmental careers; the organisation of the Medical Service within three British territories (and the impact of this organisation upon typical 'in-field' experiences); and finally, how common points of reference, based upon shared professional as well as social and cultural affiliations, helped to create a colonial medical identity.

This is only one part of the multi-faceted history of the Colonial Medical Service. The perspective focuses upon personal experiences and perceptions rather than examining the development of medical policies or tracing the course of tropical medical advancements.¹ It has necessarily prioritised the cultural and social aspects of the Colonial Medical Service encounter over political, scientific and economic ones. This piece makes no claims therefore to offer a complete picture of colonial medical practice; it scrutinises things from the European perspective and concentrates upon no more than the most persistent, official and popular, ideas that impacted upon colonial medical lives.

This approach highlights the general over the particular. Although Africanists have been eager (and correctly so) to celebrate the long-overlooked histories of individual African countries, their worthy projects should not be confused with the aims of this one. One of the most striking aspects of this period was the way that sub-Saharan Africa was lumped together in both the official and popular imagination as a single entity, and was dealt with in conspicuously uniform terms by one governing body, the CO.² This in turn affected the behaviour and attitudes of British

¹ This has been done elsewhere. See DF Clyde, *History of the Medical Services of Tanganyika*, Dar Es Salaam, 1962; A Beck, *A History of the British Medical Administration of East Africa: 1900–1950*, Cambridge, MA, 1999 [1970]; JA Carman, *A Medical History of the Colony and Protectorate of Kenya: a Personal Memoir*, 1976; WD Foster, *The Early History of Scientific Medicine in Uganda*, Nairobi, 1970; O Ransford, *Bid the Sickness Cease: Disease in the History of Black Africa*, 1983

² For popular Victorian perceptions of Africa see P Brantlinger, 'Victorians and Africans: The Genealogy of the Myth of the Dark Continent', *Critical Inquiry*, 12, 1985, pp.166–203

personnel stationed there and, for better or worse, these government participants acted out their rôle essentially as cultural attachés of colonialism. CO policies recurrently emphasised generalisations over the African continent more than the specificities of each region. This tendency towards over-simplification was borne of a long tradition that enjoyed rhetorically evocative descriptions of Empire that usually paid little heed to intra-continental differences³. It assumed the intrinsic 'rightness' of the established precedents that guided Colonial Service priorities. The Service was seen as a single career rather than numerous diverse local careers. Officers could not apply to work in a particular country within the Colonial Service (although they could express a preference), so that in applying for a Medical Service job, a desire to participate in colonial life was expected to take precedence over any attraction to a particular country. Tellingly, most official policy directives were issued under blanket headings such as 'Africa East' or 'Africa West' and serve as further evidence that, in the official mindset at least, African colonial dependencies were often grouped together *en masse*. Needless to say, to the career was more important than its location. As both the unification of the EAMS in 1921 and the Colonial Medical Service in 1934 show, there was an ongoing desire to standardise personnel management as far as possible and encourage transfers between the colonies.⁴ From the time when MOs applied for their jobs until their careers ended, the official policies directed them towards improving the workability of the bureaucracy; the objective was to strive towards uniformity and similarity before individuality and distinctiveness could be considered.

Officers were selected based upon certain ideas of 'good' colonial types; they were attracted to colonial life because of certain commonly perceived advantages and stereotypes. Once selected and in position, officers found that they worked within the official limitations of one powerful parent institution as well as within the tacit cultural boundaries of a highly conservative Empire. An exploration of these broad frameworks does not challenge the individual characters of the countries or the particularities of individual colonial experiences. Indeed, once in the location, people

³ Not least because sovereignty and borders changed during the early colonial period.

⁴ 49 of 424 officers served in more than one East African colony in the course of their Colonial Service career; others went on to serve in other parts of the empire (after East Africa).

often emphasised and celebrated their place-specific experiences, alongside expressions of their Britishness (Chapter 5). What is interesting is that ideas of supposed Britishness were as generalised and selectively used as were widespread ideas of the African continent. Colonials frequently defined their identity through associations that embraced concepts of home as much as a recognition of African-situated difference. The colonial experience was, it has been argued, a hybrid of these two ideologies.

There are ways, of course, that this study could have been broadened; chapters could, for example, have looked more precisely at the scientific identity of the medical cohort. How did the content of the tropical diploma courses offered in London, Liverpool, Cambridge and Edinburgh impact upon policies and practices transported to the tropical world?⁵ More, too, could be said on the issue of how scientific research fitted into the way officers saw themselves. The growth of scientific identity, although touched upon in Chapter 5, could also have been traced in relation to the development of laboratory medicine in Kenya, Uganda and Tanzania.⁶ It would have been interesting to chart the development of research interests in fields such as malariology or parasitology, and to analyse how these interests influenced the development of colonial medical practice and the scientific self-image of the colonial medical community. Certainly, individual research contributions from the East African field contributed substantially to advances within tropical medical science during the colonial period.⁷ In the analysis presented here individual contributions have been surrendered in favour of looking at the universal features of the job. The case studies documented in Appendix 5 will, it is hoped, help to flesh out some of the realities of individual experiences within the generalities described in this work.

⁵ Some of this information can be gleaned from H Power, *Tropical Medicine in the Twentieth Century. A History of the Liverpool School of Tropical Medicine*, 1999; L Wilkinson and A Hardy, *Prevention and Cure: The London School of Hygiene and Tropical Medicine A 20th Century Quest for Global Public Health*, 2001

⁶ This has been partly done by W Eckart, *Medizin und Kolonialimperialismus, Deutschland, 1884–1945*, München, 1997; Foster, *Early History of Scientific Medicine in Uganda*

⁷ As has been done by: J Farley, *Bilharzia: A History of Imperial Tropical Medicine*, Cambridge, 2003 [1991]; DM Haynes, *Imperial Medicine: Patrick Manson and the Conquest of Tropical Disease*, Pennsylvania, 2001

The period covered by this study was one in which medicine in the colonies changed considerably. Important country-specific developments include the development of medical education for Africans in Uganda, the growth of interest in public health, and the history of campaigns against prevalent tropical diseases such as sleeping sickness or malaria.⁸ This work does not closely examine the reception of medical initiatives by the African communities, although there is evidence to suggest that they were not always gratefully or passively received.⁹ No doubt, if some of the theories were applied to the arguments presented here, it would also be found that African resistance and negotiation was a factor in influencing the way that MOs behaved and the types of practices that they embodied.¹⁰ These approaches, however, have not been the main focus of this work. An exploration of the colonial medical identity provides a lens through which to view the assumptions, expectations and, sometimes, contradictions that informed the experiences of government medical staff during this period. However uneasy an exploration of exclusively European relationships with the colonies may sit within our post-colonial consciences, it can still be acknowledged as part of the colonial story.

6.2 The Post-War Period

To complete the picture, brief mention needs to be made of the developments that occurred in the Colonial Medical Service after World War Two. Ann Beck described the situation that the EAMS found itself in by 1939 as “vulnerable” and under massive financial stress. She describes how the Service gradually shifted towards a

⁸ These histories have been told amply well elsewhere. J Iliffe, *East African Doctors: a History of the Modern Profession*, Cambridge, 1999; EE Sabben-Clare, DJ Bradley and K Kirkwood (eds.), *Health in Tropical Africa During the Colonial Period*, Oxford, 1980; KA Hoppe, *Sleeping Sickness Control in British East Africa, 1900–1960*, Westport, CT, 2003; M Dobson, M Malowany and R Snow, ‘Roll Back Malaria: The History of Malaria and its Control in Twentieth Century East Africa’, *Wellcome Trust Review*, 8, 1999, pp.54–7; M Dobson, M Malowany and D Stapleton (eds.), ‘Dealing with Malaria in the Last 60 Years: Aims, Methods and Results’, *Parassitologia*, 2, 2000; Randall Packard examines the history of malaria control in a wider context. R Packard, ‘No Other Logical Choice’: Global Malaria Eradication and the Politics of International Health’, *Parassitologia* 40, 1998, pp. 217–30

⁹ Eg, Trowell recalled that Africans had their own medical systems and were not easily persuaded towards the western model. RHL/MSS.Afr.s.1872/144b HC Trowell, interviews, tape 1B, [n.d. c.1984], p.8; WV Kendall, a Sanitary Officer, recalled how he lost his forearm when he was attacked by villagers in the Luwere region, Uganda. They were resisting the enforcement of plague quarantine measures. RHL/MSS. Afr.s.2032, WV Kendall, ‘Extracts from the Diaries, Letters and Memory of W.V. Kendall whilst Serving in the Colonial Civil Service Uganda Protectorate 1922–1930’, p.6

¹⁰ M Vaughan, *Curing Their Ills: Colonial Power and African Illness*, Padstow, 1991; D Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*, California, 1993

more modern approach, with more official focus placed upon public health programmes and the sponsorship of field-based scientific research.¹¹ Central office in London faced many problems: most importantly the manpower pressures and financial stresses created by World War Two. In an active attempt to avoid repeating the severe recruitment problems that the Service experienced during World War One, the CO made every effort in its publicity to emphasise that officers could serve their country through membership of the Colonial Service as well as joining the fighting ranks.¹² Despite these efforts there was still a considerable reduction in medical recruitment during the war years and in 1942 it came almost to a standstill. To make up this deficit, MOs in Africa were not allowed to leave their posts or were transferred to active war service. Many who were due for retirement were retained in service.¹³ After the war the urgent need for new recruits quickly meant that the entry requirement of the DTM&H was waived for new MOs. It became normal instead for MOs to take the course when on leave, usually after their first tour of duty.¹⁴ Although there was a brief resurgence in the popularity of the career after the second war, competition from other careers also became more pronounced in this period and there were worries that the Colonial Service would be under-staffed.¹⁵ Crisis point did not arrive, however, and by 1946 the Colonial Service had grown considerably, with just under three thousand appointments across the board.¹⁶ Yet, the career was still, despite Furse's best efforts, regarded as having a relatively low profile (largely caused by the uncompetitive terms offered) when compared to other public services.¹⁷ With increasing moves towards independence in the colonies, the British Colonial Service was reorganised in 1954 under the title of Her Majesties Overseas Civil Service (HMOCS). In 1966 the Colonial Office was merged with

¹¹ Beck, *History of British Medical Administration*, p.149

¹² C Jeffries, *Partners For Progress: The Men and Women of the Colonial Service*, 1949, p.19

¹³ P Holden, *Doctors and Other Medical Personnel in the Public Health Services of Africa, 1930–1965*, Oxford, 1984, p.6

¹⁴ *Ibid.*, p.10

¹⁵ In 1943 Furse submitted a scheme for post-war Colonial Service training, endorsed by the Duke of Devonshire.

¹⁶ For post war developments see LA Mills 'Methods of Appointment and Training in the British and Dutch Colonial Civil Service', *APSR*, 33, 1939, pp.465–72

¹⁷ Jeffries, *Partners For Progress*, p.81, p.21

Commonwealth Relations Office, which in turn became part of the Foreign Office. This effectively signalled the end of the Colonial Service, although some of its aims and functions lived on in a reduced HMOCS right up until the handing over of Hong Kong to China in 1997.¹⁸

By the 1940s the Colonial Service was quite different to the organisation it had been at the turn of the century. Colonial policy in general was beginning to move away from notions of native-administration and indirect rule, and looked instead towards setting up systems of local government. Working within this changed emphasis, plans were centrally developed between 1943 and 1954 for the expansion and progressive development of the Colonial Service. In 1943 Furse presented a new post-war plan for the training and preparation of candidates. Additionally, the Colonial Development and Welfare Acts of 1940 and 1945 abolished the principle that the colonies should be financially self-supporting. Instead these acts decreed that a proportion of crown monies should be expressly laid aside for the development of colonial societies in general and for the training of new officers in particular. In the second act of 1945 a grant of £1.5 million was earmarked for a ten-year training programme.¹⁹ The 1946 government White Paper entitled the *Organization of the Colonial Service*, gives a feel for the new priorities: key points included financing the training of experts to work in the colonies and “co-ordinating the distribution of staff so that the available resources are disposed to the best advantages of the colonies as a whole”.²⁰ It warned that in the colonies “the younger generation will expect a place in Native Administrations, with a freer hand in their control”. The government spoke of “the fundamental change to be expected”; not only did Britain have to acknowledge the need to allow native peoples to actively participate in their own governance, but they saw that they could no longer pursue policies and actions solely “according to what seems best to us”.²¹ Partnership rather than trusteeship was the

¹⁸ A Kirk-Greene, *A Biographical Dictionary of the British Colonial Service, 1939–1966*, 1991, p.vi

¹⁹ A Kirk-Greene, *On Crown Service: A History of HM Colonial and Overseas Civil Services, 1837–1997*, 1999, p.47

²⁰ *Organization of the Colonial Service*, 1946, Parliamentary Papers, Col. No. 197, reproduced in *Ibid.*, pp. 202–9, p.203

²¹ C Dundas, Governor of Uganda, Dispatch to the Colonial Office and Ugandan Provincial Administration on Postwar Africa, May 1942, reproduced in *Ibid.*, pp. 216–9, p.218

order of the day; development was pursued, but for the first time with an insight into probable independence.²²

From the 1930s onwards pictures of economic productivity, with bright cocoa groves, banana plantations and rubber forests, gradually replaced the images of Empire conjured up by the title of Stanley's *In Darkest Africa* as important visual representations of the continent.²³ The idea of development became more pronounced (albeit voiced in terms of *mutual* benefit). The notion of non-reciprocated aid was raised for the first time. Widespread educational initiatives were introduced. The new emphasis also affected the way native populations perceived their colonial rulers. As Beck has pointed out, increasing demands were made about the type of healthcare that they expected and local populations began participating actively, with more power than ever previously, in the course of their own country's medical development.²⁴

Clearly, this new language of colonialism would have affected officers' behaviour and their collective perceptions of their rôle. These changes also fundamentally altered the ethos of the Colonial Service, but in other ways, the Service continued to be predicated upon essentially conservative 'establishment' ideals — especially in the way it was organised. Furse remained in charge of recruitment until 1948 and his succession by his brother-in-law, Francis Newbolt — who held the position as Director of Recruitment until 1954 — did very little to radically alter prevailing attitudes and expectations.²⁵ In fact, the increased regularisation and bureaucratisation of the Colonial Service that characterised the post-World War Two period in general could be seen to have actually reinforced ideas of conformity above any broadening of attitudes to embrace examples of entrepreneurial spirit. A 1951 description of the duties of a DMO stipulated as "essential" that he should "regard himself as one of a group of workers who are all

²² Jeffries, *Partners For Progress*, p.20

²³ 'The Colonial Medical Services', *BMJ*, ii, 1931, p.21

²⁴ Beck, *History of British Medical Administration*, p.151, p.165

²⁵ See Chapter 2, p.46

directing their energies towards the same end”.²⁶ In the days when the fate of Empire seemed much less sure, it was more vital than ever that officers should group together and present a united front. Old values were in retreat and officers whose careers spanned the pre and post World War Two periods complained about their demise. As one administrative officer reminisced on return to his old posting in Anglo-Egyptian Sudan, “nothing is now taken for granted. Prestige has gone, it has to be earned anew”.²⁷

Yet, despite these feelings of change and mounting insecurity, which the Medical Service experienced with as much force as any of the other branches of the Colonial Service, a new confidence came to characterise the colonial medical endeavour. Medicine came to be increasingly seen as the one defensible, even humanitarian, aspect of colonialism.²⁸ This period saw a revolution in the control of infectious disease with major repercussions for the tropical world: the development of DDT and other insecticides; the introduction of synthetic anti-malarials; improved treatment of sleeping sickness; effective drugs for the therapy of schistosomiasis and other helminthic diseases; the use of sulphones for leprosy, potent antituberculosis compounds and antibiotics for many other common bacterial diseases; and the development for the first time of an effective yellow fever vaccine. A new self-assurance profoundly affected the way the post-war generation of MOs perceived themselves; not least as these medical developments provided officers with a new powerful armoury with which to enact their rôle.

Many of the MOs that have informed this work’s findings served in the East African forces during the Second World War and then continued their colonial careers right through until independence.²⁹ Some went on to prominent positions in

²⁶ RHL/MSS.Afr.s.1872/82 JK Hunter, ‘Notices on District Medical Work in Uganda’, 1951

²⁷ J Currie, ‘Present Day Difficulties of a Young Officer in the Tropics’, Reprinted from *The Colonial Services Club Magazine*, Cambridge, [n.d. c.1932], pp.1–8, p.1

²⁸ Although subsequent histories argued that medical and scientific progress were in fact used to advance colonial aims. Eg, M Worboys, *Science and British Colonial Imperialism: 1895-1940*, University of Sussex, DPhil. Thesis, 1979; AW Crosby, *Ecological Imperialism: the Biological Expansion of Europe, 900–1900*, Cambridge, 2004 [1986]; R Macleod and M Lewis (eds.), *Disease Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion*, New York, 1988; Vaughan, *Curing Their Ills*; M Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire 1900–1940*, Cambridge, 2002 [1992]; Arnold, *Colonizing the Body*

²⁹ Eg, William Barnetson, Fairfax Bell, Ronald Heisch, Douglas Snell

other colonial dependencies,³⁰ while others went back to their home countries and used their specialised tropical knowledge there either in a consultancy or teaching capacity.³¹ A couple of East African MOs even went into prominent governmental positions in London, using their on-the-ground experiences to inform the direction of future colonial medical policies.³² Interestingly, several MOs found themselves unable to adjust to urban life in Britain and returned to East Africa for their retirement, either temporarily or permanently.³³

The colonial career put doctors, administrators, lawyers and policemen in a location that heavily influenced their perception of the world. It was an experience that informed their subsequent careers, and associated them with an important historical period, one that many officers considered to signal the last real phase of British power and greatness. Even those colonial servants that did not return to their place of posting for any length of time usually saw their career experiences as in some way self-defining.³⁴ Officers (and not only medical ones) felt their colonial careers provided experiences that were worth preserving for posterity, as witnessed by the ample contributions to the archives that exist at Rhodes House and (during the later period) at the Bristol Empire and Commonwealth Museum. Colonial experiences were also kept alive at Corona club events, and through the Overseas Pensioners Association. Membership of the Colonial Service symbolised something more than just a run-of-the-mill job — it involved its members in a personal as well as professional journey, it elevated their status and made them integral participants in

³⁰ Eg, Philip Bell (became DMS, Nyasaland); Stanley Branch (became Chief M and HO, St Vincent); Kenneth Edmundson (became Chief MO, Gibraltar and DMS, Seychelles); George Maclean (became DMS, Trinidad)

³¹ Eg, Arthur Bagshawe (became the first Director of the Sleeping Sickness Bureau, later to become the Bureau of Hygiene and Tropical Diseases); Henry Burke-Gaffney (became Assistant Director of the Bureau of Hygiene and Tropical Diseases in London, becoming its director in 1961); Percy Garnham (Reader in Medical Parasitology at the LSH&TM (1947–51) and then Professor and Director of the Department (1952–68))

³² Eg, John Buchanan (became the last Chief Medical Adviser to the CO in 1960); Claud Cole (became consulting physician to the CO, the Crown Agents and the Overseas Development Administration); William Kauntze (became first, Assistant (1941) and later, Chief (1944–7) Medical Adviser to the CO).

³³ Eg, Clifford Braimbridge (retired Kenya); Albert Paterson (retired Kenya); Arthur Williams (retired Kenya); Edwin Trim (retired Uganda)

³⁴ As is evidenced by the number of ex-Colonial Officers who wrote histories of their Colonial experiences (or about the Service in general): eg, Carman; Clark; Clyde; Foster; Gelfand; Kirk-Greene; Ransford; Schram

governance. It united career and place in an identity that was immensely evocative and enduring.

6.3 Career, Place and Identity

This examination of the colonial medical identity provides a unique and detailed description of the EAMS, putting an important aspect of British culture within a broader historical context. Colonial Medical Service recruitment policies are laid out, and the conditions and criteria that officially governed the careers of doctors in the East African Service are analysed. It outlines the official and non-official selection criteria; considers the reasons why doctors might have applied for the job; describes typical career experiences; and looks at common reasons for complaint. In doing this some important cultural assumptions have been uncovered — not least, how closely ideas of government service were related to broader conceptions of Africa as well as ideas of Britishness.

The profile that has been presented reveals a subtly distinctive sub-set of the colonial identity. Membership of the medical fraternity delicately influenced the terms of reference for the Medical Service cohort and made them distinct from their other Service colleagues. It drew doctors together in professional bonds and codes of conduct that were separate from their Service obligations, and gave them respected professional forums in which to express themselves, independent of their rank within the Service. It also gave them access to another system of professional recognition: one in which they could elevate their status by gaining extra medical qualifications, specialist publications or honorary Fellowships. Most importantly, being part of the colonial medical endeavour meant that MOs were involved, almost by default, in the new medico-scientific field of tropical medicine — a subject that prioritised in-field experiences and observations over metropolitan-based research. It seems fitting that the remit of this study spans the period of the East African colonial medical career from its roots within early medical exploration (Robert Moffat, the first Ugandan PMO, was Livingstone's wife's nephew³⁵) to the scientific modernity encapsulated by the grandson of the father of tropical medicine (Manson-Bahr who joined the Service

35 AD Milne, 'The Rise of the Colonial Medical Service', *KEAMJ*, 5, 1928–9, pp.50–8, p.50

in 1939 was the grandson of Patrick Manson).³⁶ Although during this period East Africa was never a major colonial medical research centre in its own right, the fact that the story can be traced from Livingstone to Manson-Bahr, says something about the symbolic associations of the place, linking the traditions of medicine and adventure in the pre-World War One period with medical and scientific modernity of World War Two.

The medical careers of 424 colonial doctors have been investigated to ascertain their education, backgrounds and motivation. These findings were analysed in the context of colonial identity, to gauge the conformity of MOs to prevalent ideas, and to elucidate how they used specifically medical aspects of the identity to define themselves further. Above all, although it had expressions unique to its own group, the medical identity ultimately relied upon the symbolic capital that Empire gave all members of the colonising classes. The identity was intimately related to place and celebrated the distinctiveness of colonial life over and above other unifying features. The colonial place, in this case, Eastern Africa, offered the means to enact a certain way of life.

The Colonial Service was an occupation that embodied certain class standards and to successfully enjoy the career staff had largely to conform to these views. Perhaps more than many other medical careers offered at the time, it encapsulated a desire to leave Britain and do something different, something that carried evocative associations and offered a chance, often for people of modest class backgrounds, to participate in an exciting and worthwhile venture. Charles Jeffries summed the enduring attractiveness of the career up well in 1949:

Everyone must strike a balance for himself. He must weigh up, perhaps, the satisfaction of pioneering against the deprivation of 'cultural amenities'; the pleasures of warmth and sunshine against the trials of mosquitoes and sweat; the relief from queues and washing-up against the interruption of family life and the bogy of 'two establishments'; the stimulation of seeing new countries and meeting with unfamiliar people against the parochialism of small-station 'shop'. It has been said, with as much truth (or half truth) as is to be found in

³⁶ Manson-Bahr served in Tanzania, 1939–40, Tanzania, 1946–8, Kenya 1953–62. He became a senior lecturer in clinical tropical medicine, LST&TM.

most epigrams, that the Colonial Service is the only profession in which one can live the life of a country gentleman on the salary of a civil servant. The fact is if you like the sort of life the Colonial Service has to offer you will like the Colonial Service.³⁷

Before the outbreak of the Second World War, the African experience was still loaded with popular allure, professional challenge, personal development and escape from the ills of modern life.³⁸ Career and place became intimately connected precisely because of the different experiences it gave them. As Margaret Trowell, wife of Hugh Trowell, reminisced, even though MOs and their families often felt homesick during their first tour of duty, after returning home to England they were just as often shocked to find that they had less in common with their former friends than they had presumed. They found, just as many others had done, that they had become Africa's "willing prisoners" and even though they recognised that some aspects of the colonial life were undoubtedly hard, they soon longed "to be again with people who share the same joke or even the same grumbles" and to be part of their like-minded communities.³⁹ The whole experience became deeply embedded in people's memories. It represented a period when people felt sure of their imperial rôle, and believed in their mission, albeit in an Empire that progressively became obsolete. It allowed, moreover, an escape from British life, during a time when professional options to live abroad were relatively scarce.

As this work has concentrated on personal medical experiences, it seems fitting to give some of the final words to a MO. Robert Hennessey, whose career in Uganda spanned 26 years, in many ways epitomised the most successful of colonial medical servants. After finishing his career at the Director of the Service in Uganda, he joined the Wellcome Laboratories of Tropical Medicine in London, becoming Head of Research in 1958 and Assistant Research Director from 1967–70.⁴⁰ His memoirs are a rich source; they provide his reasons for joining the Service, the premium put upon locally-gained experiences, the articulation of the differences of

³⁷ Jeffries, *Partners For Progress*, p.101

³⁸ In many ways these powerful associations still exist today. Since the collapse of the British Empire, however, there tends to be more reflection over how these ends are pursued.

³⁹ M Trowell, *African Tapestry*, 1957, p.16

⁴⁰ 'Robert Hennessey', *BMJ*, 299, 1989, pp.176–7, p.176

African life, and the genuine attachment that he formed with both East Africa as a place and the tropical medical interests that presented themselves. In short, he embodied many aspects of the colonial personality that this piece has argued for. His words speak for himself, but also could speak for many others, for they encapsulate, as does his career, some aspects of the very essence of *being* a Colonial MO.

About ten weeks later [after appointment] I landed at Mombasa and underwent a kind of enchantment. I suppose my early addiction to the works of Ballantyne, Henty, Marryat and the like was a predisposing factor. My imagination had taken me to places like those I was now seeing, and I was ready to be captivated by reality. Landscape, vegetation, people, animals, light, sound, smells—all the ingredients of the scene combined to produce a powerful impact and what turned out to be a lasting attachment.⁴¹

Even though, physically, groups of officers were often posted far apart from each other “[p]aradoxically the bush which separated them was the very thing that held them together”.⁴² More than the employment opportunities, the scientific advantages, or the promise of a sundowner on the verandah after a day struggling through the bush on a medical safari, the Colonial Medical Service provided scope for doing medicine in the service of Empire.

⁴¹ RHL/MSS.Afr.s.1872/75 RS Hennessey, ‘Learning About Disease in Uganda: 1929–44 and 1949–55’, 1983, p.1

⁴² E Trzebinski, *The Kenya Pioneers: the Frontiersmen of an Adopted Land*, 1991 [1985], p.31

Appendix 1

A Note on the Prosopography

The findings that underpin this work are based on a database containing yearly records for each Colonial MO. For organisational consistency, this data has been compiled subject to several criteria:

1. Information on Colonial MOs has been obtained by cross-referencing the *Medical Directory*, the *Colonial Office List*, and (from 1922 onwards), the local medical staff lists compiled by the PMO's returns for each East African territory.

Supplementary and confirmatory information came from the *Medical Register*; the territorial *Official Government Gazettes*; the Blue Books, (detailing the yearly statistical returns for each British territory); and, from 1936 onwards, the Colonial Medical Service's own published staff list (the "Green Books"⁴³). Extra information on more prominent figures was gathered from *Who's Who*, *Munk's Roll*, *The Dictionary of National Biography*, Robert Drew's *Commissioned Officers in the Medical Services of the British Army, 1660–1960* (1968), Anthony Kirk-Greene's *Biographical Dictionary of the British Colonial Service, 1939–1966* (1991) and Ralph Schram's privately-produced biographical dictionary, *Heroes of Health Care in Africa* (1997). Finally, information was added by checking the *BMJ* and *The East African Medical Journal* for relevant obituaries.⁴⁴

2. In points of dispute between the *Colonial Office List* and the *Medical Directory*, the Colonial Office description has been given priority—especially after World War One when the *Colonial Office List* became increasingly reliable and was subject to more rigorous update and revision than the *Medical Directory* (which relied upon voluntary self-descriptions and would reprint entries yearly without amendment unless specifically informed otherwise). For example, it was not until 1908 that rank and file MOs for East Africa were named in the biographical

⁴³ This term has been coined by Kirk-Greene see A Kirk-Greene, 'Colonial Service Biographical Data: the Published Sources', *AF&D*, 46, 1988, pp.2–16, p.4

⁴⁴ 107 obituaries or (substantial) biographical entries have been found. Also, further biographical information is contained in the archives at Rhodes House, Oxford for 13 officers. Appendix 5 contains 75 potted biographies based on all of these combined sources.

dictionary contained within each *Colonial Office List*. From 1925 there is a much better correlation between the *Colonial Office List* and the *Medical Directory*.

3. For ease of organisation, because of the time lag-factor involved in the publication of the major sources (*Medical Directory*, *Colonial Office Lists*, Territorial Staff Lists, etc.), when any year is described, the recruitment, resignation, transfer and promotion dates of persons have been recorded in the database to reflect that person's actual departmental or geographical position on December 31st of that year. For example, if a senior position, such as PMO, was held by two persons during a single year (because, for example, the earlier incumbent resigned mid-year), it is the person who holds the position at the end of the year who is recorded as holding that position in the database. This means counts of personnel would correctly display only one PMO each year for each territory. It also means that personnel statistics, when presented, reflect the situation as it was at the end of each year.

4. Invariably, territorial or regional staff lists give appointment dates. Therefore, if a MO is recorded as having joined in 1909, but is not in the *Colonial Office List* of that year (or, indeed until significantly later), they have still been counted for every year since their official appointment date. Although the *Colonial Office Lists* have been used to provide the framework of personnel distribution throughout the three territories, actual dates when available, have always informed data entry for each year. This means that a superficial comparison of the staff names given in the *Colonial Office Lists* and other sources may not always tally.

5. The colonial medical departments became relatively large and bureaucratic, and as time progressed more staff were included in departmental lists. This meant that decisions had to be made over who was to be included in the database. The guiding rule for inclusion has been whether the departmental member was medically qualified or not. This has included medically qualified members of the research departments. Sometimes the personnel of this side of the medical provision were drawn from the 'regular' (i.e. clinical) side of medicine, and sometimes the people recruited for these positions (typically as bacteriologists or entomologists) held a specialist, but not necessarily a medical, qualification (i.e. a PhD or a DSc.). I have not included these departmental members unless they have been medically trained.

The prosopography omits other members of the medical departments, including: agricultural surveyors, assistant surgeons, clerks, health inspectors, laboratory assistants, medical instructors, nurses, pharmacists, stenographers, storekeepers, and X-Ray operators.

For the sake of consistency I have included three dentists who are listed as being part of the Medical Department in my final figures, as they were an integral part of the medical cohort. Before the establishment of the Colonial Dental Service, some early dentists in the Colonial Medical Service were doctors who subsequently specialised in dentistry through need or inclination (e.g. Dr Victor van Someren).

6. Occasionally, one officer is listed as holding two positions simultaneously in the *Colonial Office List*. In these instances I have had to choose one position, so that the officer would not be counted twice in yearly figures. In each case the most senior position has been recorded on the assumption that records had not been updated.

7. Many records only give the year of birth, rather than an exact birthday. This has meant that it has been impossible to ascertain exact ages. For the sake of consistency, age of entry into the Colonial Medical Service has been ascertained simply by subtracting the date of birth from date of death to give an approximate age for each officer. This means that there is some margin of error, depending upon where an officer's birthday falls in the year.

8. A couple of doctors did not remain in service for more than a few months, usually before being transferred elsewhere, these rare instances have not been included in the prosopography.

Appendix 2

Heads of the Medical Departments

NB: Between 1903–1908 the medical departments of Kenya and Uganda were run together under the directorship of one PMO: first, Robert Moffat, who had previously been in charge of Uganda Medical Department, and second, James Will who for a short period at the end of his joint directorship led the Kenya Medical Department.

Kenya:

July 1895–1903	Walter Halliburton Macdonald [IBEAC since 1892] (<i>b.1859–d.1916</i>)
April 1903–1904	Robert Unwin Moffat [IBEAC since 1891] (<i>b.1866–d.1947</i>)
February 1904–1909	James Will (<i>b.18?–d.19?</i>)
February 1909–1921	Arthur Dawson Milne (<i>b.1867–d.1932</i>)
February 1921–1933	John Langton Gilks (<i>b.1880–d.1971</i>)
November 1933–1941	Albert Rutherford Paterson (<i>b.1885–d.1959</i>)

Uganda:

January 1898–1904	Robert Unwin Moffat (<i>b.1866–d.1947</i>)
February 1904–1908	James Will (<i>b.18?–d.19?</i>)
September 1908–1919	Aubrey Dallas Percival Hodges (<i>b.1861–d.1946</i>)
February 1919–1922	Clare Aveling Wiggins (<i>b.1876–d.1965</i>)
August 1922–1923	John Hope Reford <i>Acting</i> PMO
July 1923–1928	John Hope Reford (<i>b.1873–d.1957</i>)
January 1928–1933	Gerald Joseph Keane (<i>b.1880–d.1943</i>)
March 1933–1941	William Henry Kauntze (<i>b.1887–d.1947</i>)

Tanzania:

1917–1919	Arthur Horn (<i>b.1871–d.1943</i>)
October 1919–1924	John Bernard Davey (<i>b.1875–d.1967</i>)
December 1924–1932	John Owen Shircore (<i>b.1882–d.1953</i>)
January 1932–1935	Albert Harold Owen (<i>b.1880–d.1936</i>)
March 1935–1945	Ralph Royslance Scott (<i>b.1893–d.1978</i>)

Appendix 3

Service Dates of MOs Kenya, Uganda & Tanzania: 1893–1939

[NB: service dates spent in other colonial territories are not listed.]

Adams jnr., Frederick Vasey: Tanzania (1928–1936)
Adams, Ernest Beadon: Kenya (1903–1906)
Aitken, William John: Tanzania (1926–?)
Allen, George Vance: Kenya (1921–1927)
Anderson, Theodore Farnworth: Kenya (1928–1945; 1949–1957)
Ansorge, William John: Uganda (1895–1898)
Archibald, Robert George: Uganda (1906–1908)
Armstrong, James Septimus: Tanzania (1925–1936)
Auden, Francis Thomas: Kenya (1919–1922)
Austin, Thomas Aitken: Tanzania (1939–1943)
Bagshawe, Arthur William Garrard: Uganda (1900–1908)
Baker, Clement John: Uganda (1903–1922)
Baker, Henry Hugh: Kenya (1908–1909)
Balfe, Basil George Hamilton: Tanzania (1939–?)
Barnetson, William: Uganda (1936–1962)
Barrett, Raymond Edward: Uganda (1928–1955)
Bartlett, James Henry: Kenya (1937–1953)
Bateman, George Stanley: Uganda (1913–1937)
Bateman, George William Barthrop: Uganda (1937–1950)
Bateman, Herbert Raymond: Uganda (1908–1910)
Battson, Alfred Ansell: Kenya (1926–1929); Uganda (1929–?)
Bayon, Enrico Pietro Giorgio: Uganda (1907–1910)
Bell, David: Kenya (1926–1949)
Bell, Fairfax: Tanzania (1935–1960)
Bell, Philip Shaw: Tanzania (1926–1938)
Beven, John Osmonde: Kenya (1921–1927)
Black, John Jamieson: Uganda (1930–?)
Blackwood, Archibald McAllister: Tanzania (1919–1939)
Blomfield, Douglas Miles: Kenya (1936–?)
Boase, Arthur Joseph: Uganda (1924–1958)
Bödeker, Henry Albert: Uganda (1899–1902); Kenya (1902–1913, 1914–1918 & 1920)
Boon, Alfred Henry: Kenya (1919–1920)
Bowden, James William: Kenya (1929–1931)
Bowles, Roger Vincent: Uganda (1928–1933)
Brambridge, Clifford Viney: Kenya (1920–1956)
Branch, Stanley: Uganda (1900–1903)
Breeks, Charles Wilkinson: Tanzania (1921–1922)
Brennan, Charles Henry : Kenya (1921–1936)
Briscoe, Ralph Cay: Kenya (1920–1936)
Broadbent, Marcus Stanley Reuss: Kenya (1929–1932)
Brooks, John Edward: Uganda (1921–1924)

Brown, Arthur Forbes: Uganda (1928–1950)
 Brown, John Scott: Uganda (1929–?)
 Buchanan, John Cecil Rankin: Tanzania (1925–1928, 1931–1936); Uganda (1943–1945)
 Bullen, Walter Alexander: Kenya (1926–?)
 Burfield, George Alfred: Tanzania (1939–?)
 Burges, Cyril Philips: Uganda (1924–1925)
 Burke-Gaffney, Henry Joseph O'Donnell: Tanzania (1925–1946)
 Burton, Edward: Uganda (1930–?)
 Bury, Raymond: Tanzania (1930–1933)
 Butler, George Guy: Tanzania (1920–1925)
 Caddick, Charles John: Kenya (1922–1931)
 Caldwell, John Colin: Uganda (1921–1931)
 Caldwell, John McCormick: Uganda (1939–1955)
 Callanan, John Charles Joseph: Kenya (1921–1946)
 Calwell, Hugh Gault: Tanzania (1930–1948)
 Campbell, John McPhail: Kenya (1923–1930); Tanzania (1930–1938)
 Carman, John Ambrose: Kenya (1926–1951)
 Carothers, John Colin Dixon: Kenya (1929–1950)
 Carpenter, Geoffrey Douglas Hale: Uganda (1910–1930)
 Chapman, Wallace Milne: Kenya (1937–1939)
 Chataway, James Harold Herbert: Kenya (1926–?)
 Chell, George Russell Haines: Kenya (1908–1923); Uganda (1923–1933)
 Cherrett, Bertham Walter: Kenya (1910–1918)
 Chevallier, Claude Lionel: Kenya (1901–1923)
 Chilton, Noel: Tanzania (1929–?)
 Cimino, Hugo Gerard: Uganda (1921–1923)
 Clanchy, Arthur Daniel: Uganda (1913 only)
 Clark, Ernest Malcolm: Kenya (1937–1961)
 Clark, James McKillican: Kenya (1916–1918); Tanzania (1918–1927)
 Clarke, Madeleine Harvey: Tanzania (1927–1932)
 Clearkin, Peter Alphonus: Kenya (1916–1925); Tanzania (1925–1932)
 Clemmey, Albert Victor: Tanzania (1928–?)
 Cobb, Geoffrey Francis: Kenya (1938 only)
 Cobbe, Thomas Jacob: Uganda (1910–1912)
 Cochrane, Thomas Saville: Kenya (1926–1927)
 Coghlan, Bernard Augustine: Tanzania (1926–?)
 Cole, Arthur Claud Ely: Tanzania (1938–1960)
 Cole, Harry Arnold: Kenya (1926–1930)
 Collar, Frank: Kenya (1913–1915)
 Collyns, John Moore: Uganda (1906–1927)
 Connell, William Kerr: Tanzania (1924–1946)
 Connolly, Patrick Paul Daly: Kenya (1926–1946)
 Cook, Ernest Neville: Uganda (1926–1936)
 Cooke, Eric Robert Nathaniel: Kenya (1939–1951)
 Cormack, Robert Pairman: Uganda (1926–1928); Kenya (1928–1945)
 Corson, James Frederick: Tanzania (1925–1939)
 Cowen, Charles Edmund: Kenya (1930–1936)

Cowin, Philip John: Uganda (1930-?)
 Crawford, Robert Phillips: Tanzania (1919-1920)
 Crichton, Arthur John Moncrieffe: Tanzania (1920-1922)
 Cronyn, Hugh Desmond: Kenya (1931 only)
 Cumming, Patrick Grant: Kenya (1926 only)
 Dakers, Bernard William: Kenya (1920-1925)
 Davey, John Bernard: Tanzania (1919-1924, 1941-43)
 Davies, Cyril Sims: Kenya (1929-1932)
 Davies, Henry Norman: Tanzania (1926-1958)
 Davies, John Rodyn: Kenya (1925-1938)
 Davison, Eric Alan: Kenya (1921-1924)
 De Boer, Henry Speldewinde: Kenya (1920-1931); Uganda (1933-1938, 1942-1947)
 De Smidt, Frank Philip Gilbert: Kenya (1926-1936)
 Dennard, Leslie David: Uganda (1924-1937)
 Densham, Walter Arnold: Uganda (1905-1907)
 Dickson, Robert Francis Goldrick: Kenya (1928-1933)
 Doble, Francis Carminow: Uganda (1913-1917)
 Dodds, Horatius Bonar: Kenya (1903-1905)
 Donald, David: Kenya (1899-1900)
 Donnison, Cyril Percy: Kenya (1925-1928)
 Dowdeswell, Roland Melville: Kenya (1930-1950)
 Drake-Brockman, Ralph Evelyn: Uganda (1900-1902); Kenya (1902-4)
 Drury, Graham Dru: Kenya (1929-1946)
 Duke, Herbert Lyndhurst: Uganda (1910-1936)
 Dunderdale, Geoffrey: Kenya (1913-1916)
 Dunlop, Ronald Yorston: Uganda (1935-1946)
 Dye, William Hood: Tanzania (1925-1934); Uganda (1934-?)
 Earl, John Cecil St George: Uganda (1923-1943)
 Eccles Davies, Sidney Richard: Uganda (1920-1923)
 Edmond, John James Balmano: Tanzania (1922-1933)
 Edmundson, Kenneth: Tanzania (1928-1953)
 Edwards, Charles Stanstay: Kenya (1911 only)
 Enzer, John: Kenya (1925-?)
 Esler, Alexander Rentoul: Kenya (1924-1938)
 Fairbairn, Harold: Tanzania (1925-1951)
 Fisher, Harold Mayston: Tanzania (1919-1946)
 Fisher, Richard William Middleton: Kenya (1906-1907)
 Fisher, Vicars Maddison: Kenya (1919-1933)
 Fitzpatrick, Owen: Tanzania (1923-1926)
 Fleming, Alan McKinsty: Uganda (1929-1933)
 Floyd, Henry Gilbert: Uganda (1931-?)
 Foley, Edwin John: Tanzania (1937-?)
 Follitt, Harold Harold Bailly: Tanzania (1928-1931)
 Forbes, John: Kenya (1921-1937)
 Forrest, Stanley: Uganda (1925-1939); Tanzania (1939-?)
 Forster, Arthur Frost: Kenya (1907-1910)
 Fraser, Alexander Donald: Uganda (1908-1911)
 Freeman, Frank Percy: Uganda (1924-1930)

Freeth, Arthur Causton: Uganda (1924–1930)
 Gallagher, Gerald Hugh: Tanzania (1920–1921)
 Garde, Alfred Jervoise: Uganda (1931–1935)
 Garnett, Donald Goddard: Uganda (1924–1927)
 Garnham, Percy Cyril Claude: Kenya (1925–1947)
 Gibbon, Geoffrey McKay: Uganda (1938–?)
 Gilkes, Humphrey Arthur: Uganda (1939–?)
 Gilks, John Langton: Kenya (1909–1933)
 Goldie, Walter Leigh Mackinnon: Kenya (1905–1908)
 Goodliffe, John Henry: Uganda (1905–1921)
 Gordon, Henry Laing: Kenya (1931–1937)
 Graham, John Wallace: Tanzania (1925–1935)
 Gray, Arthur Claypon Horner: Uganda (1904–1909)
 Gray, John Macfarlane: Uganda (1925–1933)
 Grieve, Ian Martin Donaldson: Kenya (1929–1931)
 Griffin, Robert George: Uganda (1921–1930)
 Guinness, Ernest Whitmore Newton: Kenya (1920–1922)
 Hailstone, John Edward: Uganda (1909–1929)
 Hale, George Samuel: Kenya (1926–1951)
 Hamilton, Henry Fleming: Kenya (1918–1919)
 Hamilton, Robert: Kenya (1911–1914)
 Haran, James Augustine: Kenya (1898–1920)
 Hargreaves, George McNeill: Kenya (1928–1934)
 Harkness, John: Tanzania (1927–?)
 Harley-Mason, Robert John: Kenya (1921–1948)
 Harris, Brian Poulett: Kenya (1936–?)
 Hartley, Evelyn Francis: Kenya (1938–?)
 Haworth, Wallace Ellwood: Tanzania (1920–1924)
 Haynes, William Secretan: Kenya (1937–?)
 Heard, William Haughton: Kenya (1912–1918)
 Heisch, Ronald Brodie: Kenya (1939–1964)
 Helme, Arthur Crofts de Beetham: Tanzania (1935–1938)
 Henderson, Frederick Louis: Kenya (1904–1937)
 Hennessey, Robert Samuel Fleming: Uganda (1929–1944, 1949–1955)
 Herridge, Margaret Alex Lindsay: Kenya (1930–1937)
 Hinde, Sidney Langford: Kenya (1895–1915)
 Hodges, Aubrey Dallas Percival: Uganda (1898–1919)
 Holliday, Margaret: Uganda (1926–1933)
 Holmes, Gerald: Uganda (1930–?)
 Horn, Arthur: Tanzania (1917–1919)
 Horowitz, Eric Mark: Kenya (1935–1938)
 Howat, Clarence Hugh: Tanzania (1931 only)
 Howell, Alan Taylor: Kenya (1926–1947)
 Hunter, James Kellock: Uganda (1938–1958)
 Hunter, Ronald Nelson: Kenya (1921–1934)
 Hutchinson, William John: Kenya (1926–1929)
 Hutton, Philip William: Uganda (1937–1961)
 Hyder, Ronald Ingham: Uganda (1930 only)

Ievers, Charles Langley: Tanzania (1918–1932)
 Irwin, Henry Francis George: Kenya (1935–1938)
 James, William Robert Wallace: Kenya (1906–1907); Uganda (1908–1910)
 Jarvis, John Fulford: Tanzania (1936–?)
 Jewell, Norman Parsons: Kenya (1914–1932)
 Jobson, Eric William Charles: Kenya (1924–1939); Tanzania (1939–?)
 Johnson, John Taylor Connell: Kenya (1898–1912)
 Johnstone, Frederick John Carlyle: Kenya (1921–1944)
 Kanulse, WH: Kenya (1920 only)
 Kauntze, William Henry: Kenya (1916–1933); Uganda (1933–1941)
 Keane, Gerald Joseph: Uganda (1908–1932)
 Keigwin, George John Williams: Tanzania (1917–1918)
 Kelly, William Patrick: Uganda (1921–1924)
 Kerr, Walter Gifford: Kenya (1938–?)
 Kingdon, Alfred Thomas Lock: Uganda (1923–1926)
 Laird, William John: Kenya (1928–1929)
 Lamborn, William Alfred Stedwell: Tanzania (1917–1918)
 Lamont, Margaret Marion Traill: Uganda (1922–1923)
 Lanceley, James Leslie: Uganda (1938–1961)
 Lane, George: Uganda (1904–1921)
 Langan, Thomas: Tanzania (1925–1931)
 Langton, Edward Athol Clarence: Tanzania (1919–1921); Uganda (1921–1937)
 Latham, Donald Victor: Tanzania (1925–1946)
 Lawlor, Mary Kathleen: Uganda (1926–1929)
 Lawson, Thomas Labatt: Uganda (1939 only)
 Lee, Sydney William Timpson: Uganda (1922–1934)
 Lester, Alexander Reginald: Tanzania (1924–1934); Uganda (1934–?)
 Leys, Norman Maclean: Kenya (1904–1913)
 Lindsey, Eric Craigie: Kenya (1906–1909)
 Liston, James Malcolm: Kenya (1935–1947)
 Lockhart, Frederick Ramsdale: Tanzania (1924–1939); Kenya (1939–?)
 Loewenthal, Leonard Joseph Alphonse: Uganda (1931–?)
 Louw, Graham: Uganda (1925–?)
 Lowsley, Lionel Dewe: Uganda (1902–1912); Kenya (1912–1916)
 Lumb, Thomas Fletcher: Kenya (1909–1923)
 Lumsden, Kenneth: Uganda (1925–1928)
 Lutze-Wallace, Cyril Randolph: Tanzania (1918–1926); Uganda (1926–1938)
 Macdonald, James Stirling: Tanzania (1921–1923)
 Macdonald, Walter Halli Burton: Kenya (1895–1908)
 Macgregor, George Alistair: Tanzania (1938–1952)
 Mackay, Arthur George: Uganda (1930–1939); Tanzania (1939–?)
 Mackay, Roderick: Tanzania (1925–1944)
 Mackie, Alfred Scott: Kenya (1919–1929); Tanzania (1929–1933)
 Mackinnon, Archibald Donald: Uganda (1894–1897)
 Mackinnon, John McPhail: Kenya (1913–1916)
 Maclean, Alan Hector: Uganda (1925–?)
 Maclean, George: Tanzania (1921–1942)
 MacLennan, Norman Macpherson: Kenya (1927–1930; 1945–?)

Macleod, Nicol Campbell: Uganda (1924–1939)
 Macmillan, Hector Alasdair: Kenya (1929–1932)
 Macmillan, Robert James Alan: Uganda (1913–1932)
 Macpherson, James Simpson: Uganda (1894–1902)
 Macqueen, Malcolm Donaldson: Uganda (1926–1932)
 Madge, John Bristo Culley: Tanzania (1928–1932)
 Mann, Harold Edward: Kenya (1895–1904)
 Manson-Bahr, Philip Edmund Clinton: Tanzania (1939–1940, 1946–8); Kenya (1953–1962)
 Marshall, Claude Herbert: Uganda (1908–1934)
 Martin, Kenneth Allan Thomas: Kenya (1925–1949)
 Massey, Thomas Hunter: Kenya (1913–1934)
 Maxwell, Edward Christopher Wood: Kenya (1930–1932)
 McConnell, Robert Ernest: Uganda (1910–1923)
 McDaniel, James: Uganda (1929–1932)
 McDonald, James Hector: Tanzania (1926–?)
 McElroy, Robert Samuel: Uganda (1924–1938); Tanzania (1938–1947); Kenya (1947–?)
 McFiggans, Robert: Kenya (1926–1953)
 McKenzie, Alan: Tanzania (1925–?)
 McLean, Neil: Kenya (1926–1947)
 McNaughton, James Garvie: Tanzania (1920–1927)
 McQuillan, Cecil James: Tanzania (1927–?)
 Meade-King, William Thomas Pearse: Uganda (1913–1914)
 Meek, Andrew Inglis: Tanzania (1922–1938)
 Michael-Shaw, Mary: Kenya (1928–1934)
 Middleton, Ian Cameron: Tanzania (1929–1940)
 Miller, Frederick Richard Lanfear: Kenya (1924–1931)
 Milne, Arthur Dawson: Uganda (1898–1903); Kenya (1904–1921)
 Milne, Hugh Campbell de Burgh: Kenya (1938–?)
 Milne, Peter: Kenya (1923–1934)
 Mitchell, Andrew Henry: Kenya (1922 only)
 Mitchell, James John: Uganda (1927–?)
 Mitchell, John Phimister: Uganda (1924–1945)
 Moffat, Robert Unwin: Uganda (1892–1906); Kenya/Uganda (1903–1906)
 Morley, Arthur Harold: Tanzania (1938–1950)
 Morrough, Alexander MacCarthy: Uganda (1900–1902; 1905–1907)
 Mostert, Henrik van Reenen: Tanzania (1926–c.1929)
 Mouat, Alexander: Kenya (1909–1915)
 Mowat, Allan Henry: Uganda (1931–?)
 Murcott, Evangel Howard: Kenya (1939–1953)
 Murphy, Michael Francis: Kenya (1920 only)
 Murray, Douglas: Uganda (1930–1939)
 Murray, Gerard John: Uganda (1937–1939)
 Neill, James Hood: Kenya (1919–1920); Uganda (1920–1928); Kenya (1928–1936)
 Neilson, Harry Ross: Uganda (1912–1934)
 Newton, Alexander Stafford: Tanzania (1925–1935)
 Nixon, Robert: Tanzania (1921–?)

Noble, George Strachan Park: Tanzania (1925-?)
 Noble, Herbert Arthur Edward: Uganda (1903-1904)
 Nolan, Thomas Henry: Uganda (1924-?)
 Nunan, Patrick Francis: Kenya (1913-1923); Tanzania (1923-1925); Kenya (1925-1935)
 O'Connell, John Mary: Kenya (1918 only)
 Owen Pritchard, William: Kenya (1903-1920); Tanzania (1920-1923)
 Owen, Albert Harold: Uganda (1912-1922); Tanzania (1922-1935)
 Owen, Hugh Brindley: Uganda (1908-1933)
 Paget, Alfred James Merrick: Uganda (1899-1900) Kenya, (1900-1904)
 Parry, James Hales: Tanzania (1919-1939)
 Paterson, Albert Rutherford: Kenya (1920-1941)
 Paterson, William Lyle: Kenya (1928-1930)
 Peacock, Norman Bligh: Kenya (1920-1922); Uganda (1923-1932)
 Peacock, William Luddington: Uganda (1915-1932)
 Peake, Howard Livingstone: Kenya (1937-c.1939)
 Pelly, Huntley Nevins: Uganda (1921-1924)
 Philip, Charles Robert: Kenya (1925-1951, 1952-1954)
 Philips, Claude Hollingworth: Tanzania (1920-?)
 Philp, Horace Robert Andrew: Kenya (1921-1922)
 Pirie, James Hunter Harvey: Kenya (1913-1918)
 Plum, Denis: Tanzania (1926-1929); Uganda (1929-1933); Kenya (1933-?)
 Pooley, George Henry: Uganda (1901-4)
 Pope, George William: Kenya (1920-1924)
 Powell, George Maurice Caleb: Tanzania (1938-?)
 Pownall, Graham Steinmetz: Uganda (c.1901-c.1903)
 Preston, Philip Geoffrey: Kenya (1929-?)
 Price, Raymond Herbert: Kenya (1906 only)
 Procter, Robert Arthur Welsford: Kenya (1921-1939)
 Pugh, John: Kenya (1910-1924); Tanzania (1924-1930)
 Quin, Joseph Archibald: Uganda (1920-1921)
 Radford, William John: Kenya (1898-1920)
 Rainsford, Cecil Ross Carthy: Uganda (1930-1942)
 Rawson, Philip Hugh: Uganda (1921-1925)
 Reford, John Hope: Uganda (1907-1928)
 Reid, Charles Barrington Balfour: Tanzania (1919-1928); Kenya (1928-1938)
 Rendle, Anstruther Cardew: Uganda (1906-1918); Kenya (1919-1921); Uganda (1921-1924)
 Reynolds, John David: Uganda (1924-1947)
 Ridgway, Joseph Chamney Atkinson: Uganda (1912-1913)
 Rigby, Edward Pim: Kenya (1939-1962)
 Roberts, Clifford Ellis: Uganda (1927-1939)
 Roberts, Maiben Albert William: Kenya (1929-1942)
 Robertson, Alexander: Kenya (1907-1914)
 Robertson, James Dick: Kenya (1930-1934)
 Robertson, Muriel: Uganda (1911-1914)
 Ross, Gilbert Matheson: Kenya (1924-1926)
 Ross, John Alexander: Kenya (1921-1928)

Ross, Percival: Kenya (1926-?)
 Ross, Philip Hedgeland: Uganda (1903-1906); Kenya (1906-1920)
 Russell, Edmund Neptune: Kenya (1913-1915)
 Sanderson, Iain: Tanzania (1925-1938)
 Scott, Douglas Somerville: Tanzania (1918-1924); Kenya (1926-1931)
 Scott, Ralph Roylance: Tanzania (1919-1945)
 Searle, Charles Frederick: Kenya (1939-?)
 Sells, Lionel: Uganda (1907-1919)
 Semple, John Mervyn: Tanzania (1922-1924); Uganda (1934-?)
 Sharp, Leonard Ernest Steigenberger: Uganda (1922-1924); Uganda (1927-1929)
 Shelley, Horace Minton: Tanzania (1939-1947)
 Shelton, Charles Frank: Tanzania (1921-1939); Uganda (1939-?)
 Shircore, John Owen: Uganda (1908); Kenya (1913-1919); Tanzania (1919-1932)
 Simpson, Francis Odell: Uganda (1919-1923)
 Skan, Douglas Alkins: Tanzania (1926-1939)
 Skelton, Dudley Sheridan: Tanzania (1920-1922)
 Sloan, Gerrard Andrew: Uganda (1925-1930)
 Sly, Edwin: Uganda (1901-1903)
 Small, Francis Victor: Uganda (1924-1930)
 Small, Robert: Kenya (1906-1918)
 Smith, William Harden: Tanzania (1935-1939); Kenya (1939-?)
 Snell, Douglas Goddard: Uganda (1936-1962)
 Spearman, Barugh: Uganda (1912-1920)
 Speirs, Robert Charles: Tanzania (1925-?)
 Spence, Reginald Westmore: Kenya (1913-1918)
 Spicer, John Robert Colquhoun: Uganda (1930-?)
 Steel, Cecil Richard: Tanzania (1925-1934)
 Stone, Philip Hartley: Kenya (1937-?)
 Stones, Robert Yelverton: Tanzania (1921-1922)
 Stoney, Ralph: Uganda (1899-1905)
 Stott, Hugh: Kenya (1939-?)
 Strathairn, George Cecil: Uganda (1903-1920)
 Suffern, Thomas Henry: Tanzania (1917-1931)
 Swarbreck, Allan Beaumont: Kenya (1929-1931)
 Talwrn-Jones, Gwilym Ambrose: Uganda (1930-1932)
 Tatchell, Philip Hemsley: Tanzania (1937-?)
 Taylor, John Archibald: Uganda (1908-1923)
 Taylor, Robert Stanley: Uganda (1914-1922)
 Theis, Stanley Edward: Tanzania (1927-?)
 Thomas, James Douglas Sanby: Kenya (1928-1931)
 Thomson, Alexander Gray: Kenya (1925-1935)
 Thomson, James Hutcheon: Kenya (1913-1923); Tanzania (1923-1928)
 Tibbles, Joseph Russell: Kenya (1926-1928)
 Tichborne, Charles Roger Hobart: Tanzania (1918-1928)
 Tilling, Harold William: Kenya (c.1931-?)
 Timms, Charles Gordon: Uganda (1922 only)
 Timms, Geoffrey Lowe: Kenya (1936-1960)
 Tonking, Harold Denis: Kenya (1927-1936)

Tothill, Walter Vincent: Tanzania (1920–1922)
 Treliving, Joyce Mary: Kenya (1934–1935)
 Trim, Edwin Alfred: Kenya (1927–1959)
 Trowell, Hubert Carey: Kenya (1929–1935); Uganda (1935–1960)
 Tudhope, William: Kenya (1913–1916)
 Tulloch, Forbes Manson Grant: Uganda (1904–1906)
 Turner, Hugh Nelson: Kenya (1929–?)
 Turton, Mary: Uganda (1921–1936)
 Twining, Cicely Norah: Kenya (1928–1931)
 Twining, Helen Mary: Uganda (1929–1932)
 Uffmann, Karl Herman Henry: Kenya (1905–1907); Uganda (1907–1908)
 Van Derwert, James Alexander Henry: Tanzania (1920–1923)
 Van Someren, Robert Abraham Logan: Uganda (1905–1925)
 Van Someren, Victor Gurner Logan: Kenya (1912–1922)
 Vassallo, Salvator Michael: Uganda (1919–1925)
 Vint, Francis William: Kenya (1927–?)
 Walker, Gerald: Kenya (1919–1922)
 Walker, John Walker: Tanzania (1929–?)
 Walker, Sydney Robert: Uganda (1898–1904); Kenya (1904–1906)
 Wallace, James Montague: Uganda (1929–1934)
 Wallington, Kenneth Tratman King: Kenya (1921–1932); Uganda (1932–1934)
 Waters, Edward John Wynstone: Uganda (1900–1902); Kenya (1902–c.1907)
 Watkins-Pitchford, Henry Otley: Kenya (1935–?)
 Webb, William Leslie: Uganda (1913–1933)
 Welch, Harvey Henry Vincent: Kenya (1913–1925)
 Welch, Thomas Burges: Kenya (1920 only)
 Wetherell, Marmaduke Cordeux: Kenya (1920–1921)
 White, Walter Croker Poole: Kenya (1906–1910)
 Wiggins, Clare Aveling: Kenya (1901–1909); Uganda (1909–1923)
 Wilcocks, Charles: Tanzania (1927–1937)
 Wilkin, Bertram Osbourne: Tanzania (1925–1954)
 Wilkins, Arthur James Walker: Kenya (1928–1931)
 Wilkinson, Wallace: Kenya (1925–?)
 Will, James: Kenya/Uganda (1904–1909)
 Willans, Norman Jeune: Uganda (1928–?)
 Williams, Arthur Donald John Bedward: Kenya (1912–1933)
 Williams, Arthur Warriner: Uganda (1931–1961)
 Williams, Gwilym Ambrose: Tanzania (1921–1932)
 Williams, Neville Scott: Uganda (1914–1926)
 Williamson, John: Tanzania (1925–?)
 Willmott, Leslie Arthur: Tanzania (1925–1933)
 Wilson, Christopher James: Kenya (1911–1928)
 Wilson, Donald Bagster: Tanzania (1929–1960)
 Wilson, Douglas Edward: Tanzania (1928–1942)
 Wilson, George Alexander: Tanzania (1933–?)
 Wilson, Gerald Richard Courtenay: Tanzania (1919–1939)
 Wilson, William Arthur: Uganda (1931–?)
 Wiltshire, Henry Goodwill: Uganda (1936–?)

Wiseman, Robert Howitt: Kenya (1934–?)
Wright, Frederick James: Kenya (1936–1953)
Young, George Campbell: Kenya (1930 only)
Young, William Arthur: Tanzania (1936–?)

NB Moffat and Will were both serving Kenya and Uganda *simultaneously* during their periods as PMO of both medical departments

Appendix 4

Obituary/Biographical Entry Index

- Allen, GV, *BMJ*, iv, 1970, p.183
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Connell, WK, *BMJ*, ii, 1952, pp.1263–4
Connell, WK, *EAMJ*, 30, 1953, p.44
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Wilson, DE, *EAMJ*, 25, 1948, p.294
Wright, FJ, *BMJ*, 313, 1996, p.556

Appendix 5

75 Case Studies

Allen, George Vance (1894–1970)

Nationality: Irish

Background: unknown

Educated: Methodist College; Queen's University, Belfast;

Qualifications: MB, ChB, BAO (1917); DTM&H (1920); MD (1927);

Family: married (1922) Sybil May Seaton (*d.* 1953), one son and one daughter; married (1954) Oriane Frances Tomkins

Career: RAMC East Africa (1917–19); MO Kenya (1920–27); Bacteriologist Federated Malay States (1927–29); Principal, College of Medicine Singapore (1929–42); interned by the Japanese in Singapore (1942–5); Vice-chancellor University of Malaya (1947–52); Treasurer Association of Universities of the British Commonwealth; Chairman the Council of Queen Elizabeth College; Deputy Pro-Chancellor, University of Kent (1963–?); died in Canterbury Kent

Principal medical interests: bacteriology; medical education

Accolades: Chairman Singapore Branch of BMA (1930–32); President Malaya Branch of BMA (1933–34); CBE (1946); knighted (1952); honorary LLD (1952 Malaya, 1958 Belfast; 1963 Aberdeen); honorary DSc (1969 Kent); Secretary British Association for the Advancement of Science (1954–63)

Anderson, Theodore Farnworth (1901–1979)

Nationality: English

Background: clerical father

Educated: Rugby School, Trinity Hall, Cambridge University, University College Hospital, London, LSH&TM

Qualifications: MA; MRCS, LRCP (1924); MB, ChB (1925); DTM&H (1930); MD (1930)

Family: married (1928) Isabel Cecile Downey; two daughters

Career: Casualty MO, University College Hospital, London (1925); private practitioner and Hon. Surgeon, Scottish Mission Hospital, Kikuyu, Kenya (1925–7); MO Kenya (1928–39); RAMC (1939–1945); DMS Somalia (1945–9); DDMS Kenya (1949); DMS Kenya (1949–57); retired 1957 in the UK, returned to Kenya after independence

Principal medical interests: malariology; nutrition

Accolades: North Persian Memorial Medal (1930); OBE (1943); CMG (1956)

Ansorge, William John (1850–1913)

Nationality: English

Background: colonial family born Mauritius; clerical father (missionary)

Educated: Royal College Mauritius; Pembroke College Cambridge; St. Bartholomew's Hospital London

Qualifications: BA, MA [n.d.]; MRCS, LRCP (1892)

Family: married (1881) Mary Matilda; two sons and one daughter

Career: Professor Royal College Mauritius (1872–80); Senior Professor Royal College Mauritius (1880–86); MO Uganda (1895–8); MO Southern Nigeria (c.1901–02); retired Mauritius; died Mauritius

Principal medical interests: natural history

Accolades: Honorary LLD; Fellow Royal Zoological Society

Archibald, Robert (1880–1953)

Nationality: English

Background: colonial family, born in India; clerical father

Educated: Dollar Academy, University of Edinburgh

Qualifications: MB, ChB (1902); MD (1918)

Family: married (1919) Olive Chapman, two daughters

Career: Hospital residencies, Northern Hospital Liverpool; St Mary's Hospital for Women and Children, Plaistow and County Asylum, Rainhill (1902–6); Lieutenant RAMC Egypt and Sudan (1906); Seconded from RAMC for Sleeping Sickness Commission to Uganda (1906–8); RAMC (1908–18); Director of Wellcome Tropical Research Laboratories Khartoum (1919–36); Director Stack Medical Research Laboratory Khartoum (1928–36); Medical Superintendent Chacachacare Leper Settlement, Trinidad (1936–1939); Director Branch County Laboratory, Poole, Dorset (1939–46); Professor Farouk University, Alexandria (1947–9); Professor of Parasitology, Farouk University, Alexandria (1949–53); died Salisbury, Rhodesia

Principal medical interests: bacteriology, parasitology; medical education

Accolades: DSO (1917); President Sudan Branch of the BMA [n.d.]; CMG (1928); knighted (1934)

Bagshawe, Arthur William Garrard (1871–1950)

Nationality: English

Background: clerical father

Educated: Marlborough; Caius College, Cambridge, St George's Hospital

Qualifications: BA (1892); MRCS, LRCP (1895); MB Bch (1895); DPH (1908)

Family: married (1910) Alice Mary Thornber (*d.* 1944); two sons

Career: House Surg., East London Hospital for Children; Asst. Med. Registrar. St. Georges Hospital, House Phys. and Senior House Surg. Great Northern Central Hospital (1896–99); MO Uganda (1900–08); Director Sleeping Sickness Bureau London (later Bureau of Hygiene and Tropical Diseases) (1908–35); President Royal Society of Tropical Medicine and Hygiene (1935–7); died South Wales

Principal medical interests: trypanosomiasis, public health, natural history

Accolades: CMG (1915); knighted (1933)

Baker, Clement John (1872–1922)

Nationality: English

Background: clerical father

Educated: Bury St. Edmunds Grammar School, Middlesex Hospital, London

Qualifications: MRCS, LRCP (1898)

Family: married

Career: House Surg., Middlesex Hospital (1898–1901); MO Bloemfontein Hospital, South Africa (1901–2); MO Uganda (1903–20); PSO Uganda (c.1920–22); died at sea
Principal Medical Interests: public health; trypanosomiasis
Accolades: Fellow Royal Society for Tropical Medicine and Hygiene; Queen's Medal and four clasps for service with the South African Field Force (1901–2)

Bateman, Herbert Raymond (1876–1961)

Nationality: English
Background: colonial family, born in India
Educated: St Thomas' Hospital
Qualifications: MRCS, LRCP (1900)
Family: married
Career: RAMC (1900–33); seconded to Uganda from RAMC for Royal Society Sleeping Sickness Commission (1908–10); DDMS India and Gibraltar (intermittently); Deputy Director, Ministry of Health Casualty and Ambulance Services for England and Wales (1940–45); Chairman Medical Board, Ministry of Pensions; retired (1947); died Worthing, Sussex
Principal medical interests: trypanosomiasis
Accolades: DSO (1915)

Bayon, Enrico Pietro Giorgio (1876–1952)

Nationality: Swiss-English
Background: born in Genoa, father a Swiss in the Consular Service
Educated: Genoa, School of the Society of Friends, Sidgot; Genoa University; Würzburg; LSH&TM; Cambridge
Qualifications: MD (1902); DTM&H (1905); PhD (1938)
Family: married; two daughters and one son
Career: Assistant in Pathology, University of Geneva (1902–05); Ship Surgeon (1905–07); member of the Royal Society Sleeping Sickness Commission to Uganda (1907–10); Research Biologist, South Africa (1912–1914); Surgeon Red Cross (1914–19); pathologist British War Hospital, Napsbury (1915–19); general practice; Pathologist Molteno Animal Institute, Cambridge; died Cambridge
Principal medical interests: leprosy; natural history
Accolades: honorary MD, University of Cape Town

Bell, David (1897–1967)

Nationality: Scottish
Background: unknown
Educated: Dunfermline High School; Edinburgh University
Qualifications: MB ChB (1925); cert. H&TM [n.d.]
Family: married Barbara Robertson (Colonial Nursing Service *d.* 1966); one daughter
Career: military service France and India (1914–1920); Clinical Asst., Royal Infirmary, Edinburgh (1925–26); MO Kenya (1926–45); Seconded to RAMC (1939–45); Medical Superintendent & Principal Mulago Uganda (1945–1949); retired Colonial Service (1949); general practice, Purley, Surrey (1949–66); retired (1966)
Principal medical interests: medical education
Accolades: OBE (1943)

Bell, Fairfax (1904–1972)

Nationality: English

Background: unknown

Educated: Winchester College; Oxford; St Thomas' Hospital, London

Qualifications: BA[n.d.]; MRCS, LRCP (1929); BM, BCh (1930); MA (1930); DTM&H (1935); DPH (1948)

Family: married

Career: House appointments, St Thomas's; House Phys., Brompton Hospital (1930–35); MO Uganda (1935–48); MOH Kampala, Uganda (1948–50); MOH Kenya, (1950–60); retired Kenya with a small plantation; died Kaimosi, Kenya

Principal medical interests: natural history; public health

Accolades: unknown

Braimbridge, Clifford Viney (1892–1964)

Nationality: English

Background: unknown

Educated: Taunton School; Downing College, Cambridge; St Bartholomew's Hospital, London

Qualifications: BA, MA [n.d.]; MRCS, LRCP (1916); MB, Bch (1916); DTM&H (1924); FRCS ed. (1927)

Family: married

Career: RAMC Kenya (1916–18); MO Kenya (1920–34); Surgical Specialist Kenya (1934–56); retired (1956); died Kenya

Principal medical interests: surgery; medical (surgical) education

Accolades: MVO (1930); CBE(1950); President Association of Surgeons of East Africa (1949)

Buchanan, John Cecil Rankin (1896–1976)

Nationality: Scottish

Background: colonial family, father served in Nyasaland

Educated: Stewart's College, Edinburgh; Edinburgh University

Qualifications: MB, ChB (1923); DTM&H (1925); MD (1928); MRCP ed. (1930)

Family: married (1931) Eileen Robertson; no children

Career: military service (1915–21); House Phys. Edinburgh City Hospital (1921–25); MO Tanzania (1925–28); MO Somaliland (1928–31); MO Tanzania (1931–36); SMO Somaliland (1936–37); SMO Aden (1937–43); DDMS, Uganda, (1943–45); DMS Fiji, (1945–8); military service in World War Two; Deputy Chief Medical Officer, Colonial Office (c.1948–60); Chief Medical Officer, Colonial Office (1960–?)

Principal medical interests: trypanosomiasis; general tropical medicine

Accolades: CMG (1948); Knight Order of the Grace of St John (1961)

Burke-Gaffney, Henry Joseph O'Donnell (1901–1973)

Nationality: Irish

Background: unknown

Educated: Trinity College, Dublin

Qualifications: BA (1922); MA [n.d.]; MB, ChB, BAO (1924); MD (1931); Cert. H&TM [n.d.]

Family: married; two sons

Career: MO Tanzania (1925–29); Asst. Bacteriologist (1929–36); Senior Pathologist (1936–46); Asst. Director Bureau of Hygiene and Tropical Diseases (1946–61); Director Bureau of Hygiene and Topical Diseases (1961–68)

Principal medical interests: medical education; bacteriology

Accolades: OBE [n.d.]; Vice-President, Royal Society of Tropical Medicine and Hygiene (three terms between 1963–72)

Caldwell, John McCormick (1914–1955)

Nationality: Irish

Background: unknown

Educated: Dublin High School; Dublin University; Liverpool University, London University

Qualifications: BA (1937); MB, BCh (1937); DTM&H (1939); DPH (1947)

Family: married; two daughters

Career: MO Uganda (1939–50); seconded to the East African Forces Abyssinia (1939–45); SMO Uganda (1950–54); ADMS (1954–55); died in Kampala while on service

Principal medical interests: public health

Accolades: unknown

Carman, John Ambrose (1899–1994)

Nationality: English

Background: unknown

Educated: Highbury County School; London Hospital; LSH&TM

Qualifications: MRCS, LRCP (1924); MB, BS (1925); DTM&H (1929); MD (1929); Diploma Anaesthetics (1936)

Family: married; one son

Career: military service (1917–18); Resident MO Royal Mineral Water Hospital Bath [n.d.]; MO Kenya (1926–39); Specialist Anaesthetist Kenya (1939–51); military service World War Two (1939–45); churchwarden Nairobi Cathedral; retired UK

Principal medical interests: anaesthetics; parasitology

Accolades: President Kenya Branch BMA; Editor *East African Medical Journal*

Carothers, John Colin Dixon (1903–1990)

Nationality: English (?)

Background: colonial family, born South Africa, father a civil engineer in the Admiralty

Educated: Portsmouth Grammar School; St. Thomas' Hospital

Qualifications: MRCS, LRCP (1926); MB, BS (1927); DPM (Diploma Psychiatric Medicine) (1946)

Family: married Diana (1933); three children

Career: MO Kenya (1929–38); Specialist Psychiatrist Kenya (1938–50); Psychiatric Specialist, St James' Hospital, Portsmouth (1951–59); Consultant Specialist, St James' Hospital, Portsmouth (1959–c.1965)

Principal medical interests: psychiatry; natural history

Accolades: Fellow Royal College of Psychiatrists

Carpenter, Geoffrey Douglas Hale (1882–1953)

Nationality: English

Background: prestigious academic family, father and grandfather both FRS

Educated: Dragon's School; Bradfield College; St. Catherine's College, Oxford, St George's Hospital

Qualifications: BA (1904); MRCS, LRCP (1908); BM, Bch (1908); DM (1913)

Family: Amy Frances Thomas-Peter (1919); no children

Career: House Surg., House Phys., St. George's Hospital (1908–09); MO Uganda (1910–20); Captain Uganda Medical Service (1914–18); SMO Uganda (1920–30); Special Investigation into Sleeping Sickness, Ngamiland (1930–31); Fellow Jesus College Oxford (1933–48); Hope Professor of Entomology, Oxford University (1933–48); died Cumnor Hill, Oxford

Principal medical interests: natural history; trypanosomiasis

Accolades: MBE (1918); Vice-President Linnean Society (1935–36); President Royal Entomological Society (1945–46)

Clearkin, Peter Alphonsus (1887–1971)

Nationality: Irish

Background: large not wealthy Irish Catholic family

Educated: Queen's University Belfast, LSH&TM

Qualifications: MB, Bch, BAO (1912); DPH, (1923); MD, (1930)

Family: married (1918) with three sons (all members of medical profession)

Career: private practice, Durham (1912); Asst. MO Oxford County Mental Hospital (1913); MO Sierra Leone (1914–16); MOH Nairobi, Kenya (1916–18); MO Kenya (1918–20); Pathologist and Assistant Bacteriologist, Kenya (1920–25); DDLS Tanzania (1925–32); Research Fellow, Queen's University Belfast (1933–8); Government Bacteriologist and Pathologist Guyana (1938–45); DLS Trinidad (1945–47); Secretary, Faculty of Medicine, Queen's University Belfast (1947–51); Government Pathologist Cyprus (1951–8); Consultant Haematologist, St. Kevin's Hospital, Dublin (1958); Retired in Dublin; in final years moved between Jersey and South Africa, died in native Ireland

Principal medical interests: bacteriology

Accolades: OBE (1945)

Cole, Arthur Claud Ely (1909–1989)

Nationality: English

Background: missionary father (in China); missionary grandfather (in India)

Educated: Winchester College; Trinity College, Cambridge, St. Mary's Hospital, London

Qualifications: BA, MA [n.d.]; LMSSA (1934); MB, Bch (1935); MRCP (1936); MD [n.d.]

Family: married Joan

Career: military service (1939–43); Medical Specialist Tanzania (1943–60); Consultant Physician Hospital for Tropical Diseases, London (1960–75); Consulting Physician,

Colonial Office, the Crown Agents, Overseas Development Office, hospital consultant (1975–80); retired Isle of Man

Principal medical interests: parasitology

Accolades: Fellow Royal College of Physicians

Connell, William Kerr (1893–1952)

Nationality: Scottish

Background: unknown

Educated: Glasgow University, LSH&TM

Qualifications: MB, ChB (1916); DTM&H (1930)

Family: married Frances, no children

Career: MO, Waziristan Expeditionary Force, RAMC (1916–1920); House Surg., Glasgow (1920); Demonstrator in anatomy, Glasgow University (1921–2); House appointments, London Hospital and Beckett Hospital, Barnsley (1922–4); MO Tanzania, (1924–36); Surgical Specialist Tanzania (1936–46); Lecturer in Anatomy, Glasgow University (1948–52), died Glasgow, Scotland

Principal medical interests: medical education; surgery

Accolades: President Tanganyika Branch of the BMA (1934–5 & 1938–9)

Cook, Ernest Neville (1882–1959)

Nationality: English

Background: medical family

Educated: St Paul's School; University College London; LSH&TM

Qualifications: MRCS, LRCP (1908); MB, BS (1908); DTM&H (1925)

Family: married (1915) Aldwyn May Gordon

Career: House Surg., & Demonstrator in Anatomy, University College Hospital (1908–1909); Missionary, Church Missionary Society Uganda (1909–29); Temporary MO Uganda (1926–29); MO Uganda (1929–36); retired UK; died Goring-by-Sea, Sussex

Principal medical interests: trypanosomiasis; medical education, surgery

Accolades: unknown

Corson, James Frederick (1878–1963)

Nationality: Scottish

Background: clerical father

Educated: Manchester Grammar School; Manchester University, Cambridge University; LSH&TM

Qualifications: MB, ChB (1901); DPH (1911); MD (1911); DTM &H (1912)

Family: married Violet Humphreys (*d.*1918); one son; remarried (1940) Evelina Robertson

Career: MO Gold Coast (1913–20); Pathologist Gold Coast (1920–23); MO Nigeria (1923–25); Asst. Bacteriologist Tanzania (1925–29); MO Tanzania (1929–39); Bureau of Hygiene and Tropical Diseases (1943–46); died UK

Principal medical interests: trypanosomiasis; bacteriology

Accolades: MBE; OBE [n.d.]

Davey, John Bernard (1875–1967)

Nationality: English

Background: clerical father

Educated: Giggleswick School, Edinburgh University, University College London, Middlesex Hospital London, Liverpool University

Qualifications: MRCS, LRCP (1899); MB (1900); DTM (1907)

Family: married Constance (1913), two daughters

Career: house appointments, Middlesex Hospital (c.1899–1900); Civil Surgeon, South African Field Force (1900–02); MO Nyasaland (1902–19); PMO Tanzania (1919–24); Clinical Pathologist, Cheltenham (1925–33); Ships' Surgeon (1935–40); Provincial MO Tanzania (1941–3); retired to South Africa, moved back to Worthing, Sussex where he died.

Principal medical interests: parasitology

Accolades: South African War Medal and Clasp (1901); President Tanganyika Branch of the BMA (1923–4)

De Boer, Henry Speldewinde (1889–1957)

Nationality: English

Background: colonial family; born Sri Lanka

Educated: 'Private School', London Hospital, Cambridge, LSH&TM

Qualifications: MRCS, LRCP (1913); DPH (1920); DTM&H (1923)

Family: married Frances Ethel Bartholomeusz (1920), two sons (one being in the medical profession)

Career: military Service (1915–20); MO Kenya (1920–6); SSO, Kenya (1926–31); DDSS Northern Rhodesia (1931–3); DDMS Uganda (1933–8); DMS Nyasaland (1938–42) DMS Uganda (1942–7); Temporary MO Ministry of Health & Airport MO Northolt (1947–55); County Councillor for Hemel Hempstead; died Hertfordshire.

Principal medical interests: malariology; maternity and child welfare; public health

Accolades: Military Cross (1918); President Nyasaland Branch of the BMA (1938–9); CMG (1945)

Donnison, Cyril Percy (1899–1954)

Nationality: English

Background: unknown

Educated: London Hospital

Qualifications: MRCS, LRCP (1924); MB, BS (1928); MD (1930); MRCP (1934)

Family: married; two daughters (both working in medicine)

Career: Pilot Royal Flying Corps (1917–19); MO Kenya (1925–28); private practice, Benfleet and Cheltenham (c.1930); Consulting Physician Children's Department Cheltenham General Hospital (1948–1953); died Cheltenham

Principal medical interests: paediatrics

Accolades: unknown

Dowdeswell, Roland Melville (1901–1956)

Nationality: English

Background: colonial family, born Bengal

Educated: St Paul's School; Emmanuel College Cambridge, St Thomas' Hospital, LSH&TM

Qualifications: BA MA [n.d.]; MRCS, LRCP (1928); cert. H&TM (1930); MB Bch (1932); MD (1938)

Family: married (1941) Sheila Paterson; three sons

Career: MO Kenya (1930–37); Bacteriologist Kenya (1937–48); Deputy Director Laboratory Services Kenya (1948–50); Professor of Biology, University of Beirut (1950–55); Director of Laboratories El Caliouh Public Health Demonstration Project Egypt (1955–56)

Principal medical interests: bacteriology; helminthology

Accolades: Secretary Kenya Branch BMA (1939–40)

Garnham, Percy Cyril Claude (1901–1994)

Nationality: English

Background: father in the military

Educated: Paradise School, Stamford Hill; St Bartholomew's Hospital; LSH&TM

Qualifications: MRCS, LRCP (1923); MB, BS (1923); DPH (1924); MD (1928); Dip. de Médecine Malariologie University of Paris (1931); D.Sc. (1951)

Family: married (1924) Esther Long Price; two sons and four daughters

Career: MO Kenya (1925–47); Reader in Medical Parasitology, London School of Hygiene and Tropical Medicine (1947–51); Professor of Medical Parasitology, London School of Hygiene and Tropical Medicine (1952–68); Professor Emeritus, Senior Research Fellow, Imperial College of Science and Technology (1968–79); visiting Professor University of Strathclyde (1970–87); retired UK, died Buckinghamshire

Principal medical interests: protozoology

Accolades: University of London Gold Medal (1928); Darling Medal WHO (1952); Bernhardt Nocht Medal Hamburg (1958); Gaspar Vianna Medal Brazil (1962); CMG (1964); FRS (1964); Manson Medal (1966); Emile Brumpt Prize Paris (1970); Médaille d'Or Society de Pathologie Exotique (1971); Médaille de Vermeil France (1972); Mary Kingsley Medal Liverpool (1973); Rudolf Leuckart Medal Germany (1974); Honorary Fellow London School of Hygiene and Tropical Medicine (1976); Honorary Fellow Imperial College of Science and Technology (1979); Frink Medal Zoological Society (1985); Linnean Medal (1986); Honorary FRCP ed [n.d.]; Knight of Grace Mil. and Hospitaller Order of St. Lazarus of Jerusalem [n.d.]

Gilks, John Langton (1880–1971)

Nationality: English

Background: unknown

Educated: Merchant Taylor's School; St Thomas' Hospital

Qualifications: MRCS, LRCP (1904)

Family: married (1911) Margaret Annie Messom (*d.* 1957); one son (in the medical profession)

Career: House Surgeon St Thomas' Hospital; Asst. MO Wandsworth Infirmary; Asst. MO Camberwell Infirmary (1904–1909); MO Kenya (1909–20); Seconded to

East African Forces (1914–16); RSO, European Hospital Nairobi (1920–21), PMO, Kenya (1921–33); Governor St Thomas' Hospital (1926–48); Overseas Committee BMA (1935–57); member of numerous other advisory committees (1935–57); retired 1957

Principal medical interests: surgery; medical education

Accolades: FRCS ed (1908); President Kenya Branch BMA (1922–24); editor *East African Medical Journal* (1929–33); CMG (1933); Vice-president BMA (1958–59)

Gray, Arthur Claypon Horner (1878–1963)

Nationality: English

Background: clerical father

Educated: Malvern College; Guy's Hospital

Qualifications: MRCS, LRCP (1901); MB (1903)

Family: married Dorothy M; two sons and one daughter

Career: hospital residencies Guy's Hospital (1903); RAMC (1903–04) Seconded to Colonial Medical Service for sleeping sickness investigations MO Uganda (1904–09); Pasteur Institute Tunis (1912–14); Asst. Professor, Royal Army Medical College (1914–15); served in France (1915–18); prisoner of war (1918–19); War Office (1919–21); Constantinople (1922–23); India (1924–26); Professor of Pathology Royal Army Medical College (1926–34); Director Royal Army Medical College (1930–34); retired (1934); died UK

Principal medical interests: bacteriology; trypanosomiasis

Accolades: OBE (1919)

Hale, George Samuel (1899–?)

Nationality: English

Background: unknown

Educated: Westminster School, St Bartholomew's Hospital, London, Liverpool University

Qualifications: MRCS, LRCP (1925); MB, BS (1925); DTM&H, (1929)

Family: unknown

Career: military service (1918–19); House Surg., Victoria Hospital, Southend; MO, Kenya (1926–47); SMO, (1947–51)

Principal medical interests: unknown

Accolades: MBE [n.d.]

Harley-Mason, Robert John (1889–1977)

Nationality: English

Background: unknown

Educated: Brighton Grammar School; Middlesex Hospital, LSH&TM

Qualifications: MRCS, LRCP (1913); DTM&H (1924); DOMS (1928)

Family: married; children

Career: Resident MO King George Hospital and House Surg., Middlesex Hospital [n.d.]; RAMC Flanders and India (1914–20); Ministry of Pensions Hospital for Officers (1920–21); MO Kenya (1921–37); Ophthalmic Specialist Kenya (1937–48); part-time Ophthalmic Specialist Kenya (1948–56); retired first to Kenya and then to England; died England

Principal medical interests: ophthalmology
Accolades: unknown

Heisch, Ronald Brodie (1910–1969)

Nationality: English

Background: unknown

Educated: Bradfield College; Emmanuel College Cambridge, Middlesex Hospital

Qualifications: BA (1931); MB Bch (1937); MD (1948); MRCP (1962)

Family: married twice; two daughters and one son

Career: MO Kenya (1939–47); Director Medical Research laboratory Nairobi (1947–56); Senior Specialist (1956–64); Senior Lecturer Department of Parasitology, London School of Hygiene and Tropical Medicine (1964–69); died London

Principal medical interests: parasitology

Accolades: North Persian Forces Memorial Medal (1951); OBE (1961); ScD Cambridge (1961); Gaspar Vianna Medal (1964)

Hennessey, Robert Samuel Fleming (1905–1989)

Nationality: Irish

Background: unknown

Educated: International School Newry; St. Andrews College, Dublin; Trinity College Dublin; LSH&TM

Qualifications: BA [n.d.]; MB, Bch, BAO (1927); DTM&H (1929); MD (1932); Dip.Bact. (1932)

Family: married (1930) Grace Alberta Coote (*d.* 1980); one son and one daughter (both in medicine)

Career: House Surg. Armagh County Infirmary [n.d.]; MO Uganda (1929–44); Lecturer in Pathology and Forensic Medicine Makerere College Medical School, Uganda (1930–1944); Deputy Director Laboratories Palestine (1944–46); Deputy Director Department of Health Palestine (1946–49); DMS Uganda (1949–55); Head of Laboratories of Tropical Medicine Wellcome London (1955–58); Head of Therapeutic Research Wellcome London (1958–67); Asst. Research Director Wellcome Foundation (1967–70); retired Hertfordshire, died UK

Principal medical interests: pathology; medical education

Accolades: Chairman of the African Regional Committee of WHO (1953–54); FRCPI [n.d.]; CMG (1954)

Hinde, Sidney Langford (1863–1930)

Nationality: English (?)

Background: born Canada, father in the military

Educated: France; Germany; Clare College Cambridge; St. Bartholomew's Hospital London

Qualifications: BA, MA [n.d.]; LSA (1890)

Family: married Hildegard

Career: Resident MO North Stafford Hospital and Temperance Hospital London (1889–90); Congo Free State Service, Arab Campaign (1892–94); explored upper Luslaba and Lukuga (1894); British East Africa M'Baruk Campaign (1895); MO Kenya (1891–1915)

Principal medical interests: natural history

Accolades: Chevalier l'Ordre du Lion [n.d.]; Africa General Service Medal (c.1896); M'Baruk Campaign Medal (1895); Fellow Royal Geographical Society [n.d.]; Honorary Member Belgian Geographical Society [n.d.]

Hodges, Aubrey Dallas Percival (1861–1946)

Nationality: English

Background: medical father

Educated: Epsom College, London Hospital

Qualifications: MRCS, LRCP (1889); MB, BS (1890); MD (1892)

Family: married (1909) Helena Riddick (d.1925); married (1927) Hilda Margaret; one son (RAMC)

Career: House Phys., House Surg., London Hospital; Ast. MO South-Eastern Fever Hospital; MO Uganda (1898–6); SMO Uganda (1906–8); PMO Uganda (1908–19); Private Practice West Sussex (1920–29); retired in Sussex (1919), died Sussex

Principal medical interests: trypanosomiasis

Accolades: CMG (1910); Fellow Royal Institute of Public Health

Horowitz, Eric Mark (1910–1994)

Nationality: Austrian (naturalised British in 1944)

Background: unknown

Educated: Vienna; Glasgow University

Qualifications: MD (1934); LRCP Ed, LRFPS Glas. (1939)

Family: married; one daughter

Career: Temporary MO Kenya (1935–38); returned to London to study (1938–40); MO Kenya (1940–44); private practice and hospital work, Nairobi Kenya (1944–63); private practice London (1963–83); retired UK

Principal medical interests: unknown

Accolades: Chairman and Provost Kenya Branch of the BMA (1960)

Hunter, James Kellock (1913–1994)

Nationality: Scottish

Background: unknown

Educated: George Watson's College; Skerry's College; Glasgow University

Qualifications: MB, ChB (1936); DTM&H [n.d.]; DPH [n.d.]

Family: married, one son

Career: MO Uganda (1938–49); SMO Uganda (1949–52); DDMS Uganda (1952–8); Eastern Hospital Board, Scotland (1958–60); PMO and Director, Scottish Hospital Advisory Service (1960–77)

Principal medical interests: medical education

Accolades: OBE [n.d.]

Ievers, Charles Langley (1884–1965)

Nationality: Irish

Background: unknown

Educated: Edinburgh University; Liverpool University

Qualifications: LRCP, LRCS Ed, LRFPS Glas. (1910); DTM (1911)

Family: married twice

Career: independent travel (1911–12); MO Gold Coast (1912–1914); MO Togoland (1914); served in Mesopotamia World War One (1914–18); MO Tanzania (1918–21); SMO Tanzania (1921–32); in charge of evacuation train London World War Two (1939–45); retired Kenya and South Africa; died Kenya

Principal medical interests: unknown

Accolades: unknown

Kauntze, William Henry (1887–1947)

Nationality: English

Background: father banker; descendent of missionaries

Educated: Dublin; Victoria University, Manchester; London; LSH&TM

Qualifications: BA (1907); MB ChB (1911); MB BS (1912); DPH (1912); MRCS, LRCP (1913); MD (1921); MRCP (1937)

Family: married Edith Johnston (1919); one daughter

Career: Residential appointments Manchester Royal Infirmary and Salford Infirmary (1912–14); MO Nigeria (1914); seconded to RAMC served with West African forces (1914–16); Liverpool General Hospital (c.1916); served with forces in East Africa, (1916–19); Senior Bacteriologist Kenya (1919); Deputy Director Laboratory Services Kenya (1919–32); DMS Uganda (1932–41); Asst. Medical Adviser to the Colonial Secretary (1941–44); Chief Medical Adviser to the Colonial Secretary (1944–47); died in Woking

Principal medical interests: bacteriology; malariology

Accolades: Duncan Medal LSH&TM (1913); MBE (1918); CMG (1937); Knight of the Order of St. John Jerusalem (1943); FRCP (1945)

Keane, Gerald Joseph (1880–1943)

Nationality: English

Background: unknown

Educated: Mount St. Mary's College, Chesterfield; Liverpool University

Qualifications: MB ChB (1904); MD (1906); DPH (1907); DTM [n.d.]

Family: married (1923) Auriol Frances Kyrle; one son

Career: RAMC (1908–19); seconded to Uganda under the Colonial Office (1908–14); made permanent member of Uganda Medical Department (1914–19); DDMS (VD) Uganda (1919–28); Lecturer Makerere College, Uganda (1924–?); DMS Uganda (1928–33); retired Devon

Principal medical interests: trypanosomiasis; venereology; medical education

Accolades: Fellow Royal Society Tropical Medicine; Martin Gold Medal for Tropical Medicine; Tulloch Memorial Prize for Pathology [n.d.]; received thanks from the Secretary of State (twice) for anti-VD work (1908–10); DSO (1917); CMG (1930)

Lamborn, William Alfred Stedwell (1877–1959)

Nationality: English

Background: unknown

Educated: St. Mungo's College Glasgow; Middlesex Hospital

Qualifications: MRCS, LRCP (1899); MRCP (1937)

Family: married; one son

Career: Asst. MO Islington Infirmary; Asst. MO County Asylum, Littlemore, Oxford; Asst. MO St Mary's Infirmary London, (1899-1905); Asst. MO British Guiana (1905-07); MO Natal[n.d.]; MO Nigeria Bitumen Corporation (c.1909-13); Entomologist Nigerian Agriculture Department (1913-15); sleeping sickness campaign Nyasaland(1915-17); Temporary MO Tanzania (1917-18); MO Nyasaland (1918-20); Asst. Medical Entomologist Federated Malay States (1920-21); Medical Entomologist Nyasaland (1921-39); Major RAMC (1939-45)

Principal medical interests: medical entomology; trypanosomiasis

Accolades: OBE (1930); President Nyasaland Branch BMA (1937-38)

Macdonald Walter Halliburton (1859-1916)

Nationality: Scottish

Background: unknown

Educated: Royal College of Surgeons Medical School Edinburgh

Qualifications: LRCP, LRCS, LRFPS (1888)

Family: unknown

Career: PMO, IBEAC (1889-95); MO Anglo-German Boundary Delimitation Committee (1898); PMO Kenya (1895-1903); MO Kenya (1903-08); private practice Kenya (1908-c.1914); temporary commission RAMC (1914-1915); MO in charge of the troops of the Forth Defences, Scotland (1915-16); died Edinburgh

Principal medical interests: unknown

Accolades: African War Medal and Clasp (1890); Order of the Brilliant Star of Zanzibar (1895); Clasp for Mwele; East and Central Africa Queen's Medal with Clasp (1897-98); Africa General Service King's Medal (1900); IBEA Service Medal (1902)

Mackay, Roderick (1898-1966)

Nationality: Scottish

Background: unknown

Educated: Portree High School, Skye; Aberdeen University; LSH&TM

Qualifications: MB, ChB (1924); DPH (1931); cert. H&TM [n.d.]; MD (1934)

Family: married; two sons (both members of the medical profession)

Career: Royal Navy (1916-19); MO Tanzania (1925-38); SSO Tanzania (1938-44); MOH East Wiltshire (1944-59); retired (1959)

Principal medical interests: malariology; public health

Accolades: unknown

Mackie, Alfred Scott (1891-1959)

Nationality: Scottish

Background: colonial family, born in Antigua; father MO in the Colonial Medical Service, West Indies

Educated: Antigua Grammar School; Aberdeen Grammar School; Aberdeen University; LSH&TM

Qualifications: MB, ChB (1915); cert. H&TM

Family: married; one son

Career: Royal Navy (1915–19); MO Kenya (1919–29); SMO Kenya (1929–33); retired from Colonial Medical Service because of ill health (1933); Asst. Medical Practices in Ivybridge, South Devon, Fareham Hampshire (c.1933–38); principal doctor, private practice Bournemouth (1938–58); retired (1958); died Bournemouth England

Principal medical interests: unknown

Accolades: unknown

Mackinnon, Archibald Donald (1864–1937)

Nationality: Scottish

Background: clerical father

Educated: ‘private school’; Aberdeen University

Qualifications: MB, CM (1887); MD (1892)

Family: married (1901) Mary Henderson (*d.*1923); married (1925) Sylvia Joan

Career: MO Kenya IBEAC (1888–91); Civil Surgeon Cooch Behar, India (1893–94);

MO Uganda (1894–97); Director of Transport Uganda (1898–99); MO Zanzibar (1900–06); retired Isle of Skye

Principal medical interests: unknown

Accolades: CMG (1900); Order of Hamoudieh Zanzibar (1901); Order of the Brilliant Star Zanzibar [n.d.]; OBE (1919)

MacLennan, Norman Macpherson (1895–?)

Nationality: Scottish

Background: clerical father, born New Zealand

Educated: Waitaki High School, New Zealand, Aberdeen University

Qualifications: MB, ChB (1921); DPH (1923); MD (1924)

Family: unknown

Career: Lieutenant Cameron Highlanders (1915–18); Junior House Phys. & Surg., Royal Hospital Sick Children, Aberdeen (1919); RAMC (1919–1922); Asst. in general practice (1922); Resident MO, Aberdeen City Hospital (1922–3); University Clinical Pathologist, St Andrews (1923–5); Asst. MO Met. Burgh., Woolwich (1925–6); MO Kenya (1927–30); SMO Palestine, (1930); SHO, N. Rhodesia (1931); SMO Palestine (1933); DMS, British Guiana (1938); DMS, Trinidad (1942); DMS Kenya, (1945–?)

Principal medical interests: bacteriology; public health

Accolades: unknown

Manson-Bahr, Philip Edmund Clinton (1911–1996)

Nationality: English

Background: prominent colonial medical family; grandfather was Patrick Manson

Educated: Rugby School; Cambridge University; London Hospital; LSH&TM

Qualifications: BA, MA [n.d.]; MRCS, LRCP (1935); MB, Bch (1935); MRCP (1938); DTM&H (1939); MD [n.d.]

Family: married Joan; one son (a member of the medical profession) and one daughter

Career: MO Tanzania (1939–40); RAMC Abyssinia (1940–46); SMO Tanzania (1946–8); Specialist Physician Fiji (1948–53); Specialist Physician Kenya (1953–1962); Professor of Clinical Tropical Medicine Tulane University, New Orleans (1962–68);

Senior Lecturer in Clinical Tropical Medicine London School of Hygiene and Tropical Medicine (1968–75); died UK
Principal medical interests: leishmaniasis
Accolades: FRCP [n.d.]

McLean, Neil (1898–1955)

Nationality: Scottish
Background: unknown
Educated: Glasgow University; Liverpool SH&TM
Qualifications: MB, ChB (1924); DTM (1926)
Family: married (1935) G Davidson; three daughters
Career: Cameron Highlanders, France, Balkans and Russia (1914–19); MO Kenya (1926–c.1940); SMO Kenya (c.1940–46); retired from Colonial Medical Service for reasons of ill health (1946); private practice Ryde, Isle of Wight (1946–55)
Principal medical interests: trypanosomiasis
Accolades: North Persian Forces Memorial Medal (1931)

Michael-Shaw, Mary (1897–1963)

Nationality: English
Background: unknown
Educated: Royal Free Hospital, London
Qualifications: MRCS, LRCP (1922); MB, BS (1923)
Family: married
Career: Senior Asst., Venereal Diseases Department, Royal Free Hospital; House Surg., Royal Free Hospital; House Surg. London Lock Hospital (1922–28); MO Kenya (1928–34); Director, Venereal Diseases Department, Royal Free Hospital (1938–1959); Asst. to the Adviser in Venereal Diseases, Department of Health [n.d.]; retired (1959); died UK
Principal medical interests: venereology; maternity and child welfare
Accolades: President, Medical Society for the Study of Venereal Diseases (1950–51)

Middleton, Ian Cameron (1899–1973)

Nationality: Scottish
Background: unknown
Educated: Edinburgh University; Liverpool University
Qualifications: MB, ChB (1921); DTM (1929); DTH (1932)
Family: unknown
Career: military service (1917–18); House Surg., Royal Infirmary, Stirling; Senior House Surg., Royal Infirmary, Worcester; MO Tanzania (1929–40); private practice, Stirling (1940–46); private practice Stroud, Gloucestershire (1946–c.1964); retired (1964); died (1973)
Principal medical interests: unknown
Accolades: unknown

Milne, Arthur Dawson (1867–1932)

Nationality: Scottish

Background: born colonial family Kingston, Jamaica; clerical father

Educated: Gymnasium, Old Aberdeen; Aberdeen University; Charing Cross Hospital

Qualifications: MB, CM (1892)

Family: married (1913) Alison Katherine Campbell; two daughters

Career: Junior House Surg., Rotherham Hospital (1893); House Surg., Sheffield Children's Hospital (1894); Uganda Mutiny, East and Central Africa, (1897–98); MO Uganda (1898–00); African General Service (Nandi) (1900); SMO Uganda (1900–04); DPMO Uganda and Kenya (1904–09); PMO Kenya (1909–21); retired Colonial Service (1921); retired Shropshire

Principal medical interests: unknown

Accolades: General Service and Victory Medals (c. 1900) CMG (1917)

Mitchell, John Phimister (1884–1962)

Nationality: Scottish

Background: unknown

Educated: University of Aberdeen

Qualifications: MB, ChB (1907); MD (1911)

Family: married

Career: House Phys., Seaman's Hospital (the 'Dreadnought') Greenwich; private practice South Africa and Australia [n.d.]; RAMC Middle East and India (1914–19); MO Sudan Medical Service (1919–24); MO Uganda (1924–32); Med. Superintendent and Principal Mulago Medical School Uganda (1932–45); retired Aberdeenshire (1945); died Scotland

Principal medical interests: medical education

Accolades: OBE (c.1919); CBE (1944)

Moffat, Robert Unwin (1866–1947)

Nationality: Scottish

Background: colonial family born South Africa; clerical father

Educated: St Andrew's College, Grahamstown South Africa; Edinburgh University

Qualifications: MB, CM (1890); MD (1907)

Family: married (1899) Hilda (d.1912); one daughter; married (1925); Alice Loeffler

Career: MO Kenya IBEAC (1891–94); MO Uganda (1895)

Principal medical interests: unknown

Accolades: CMG (1899); Decorated for Service in Uganda Mutiny (c.1890s)

Morley, Arthur Harold (1900–1987)

Nationality: English

Background: colonial family, born Japan; missionary father

Educated: Kingswood School, Bath; Leeds University; Leeds Infirmary

Qualifications: MRCS, LRCP (1925); DPH (1930); DIM, DIH [n.d.]

Family: married, one son & three daughters (one of whom is a doctor)

Career: MO Somaliland (1928–38); MO Tanzania (1938–46); commissioned in Second World War to Abyssinia (1939–42); Surgical Specialist, Tanzania (1946–50); general practice and MOH, Ilfracombe (1950–65); died Prestwick, Ayrshire

Principal medical interests: surgery

Accolades: OBE [1950]; FRCS ed

Paterson, Albert Rutherford (1885–1959)

Nationality: Scottish

Background: unknown

Educated: Glasgow High School; Glasgow University; Cambridge University

Qualifications: MB, ChB (1908); DPH (1920); DTM&H (1920)

Family: married (1931) Madeline Ruth Alice; three sons and one daughter

Career: House Physician and House Surg., Glasgow Royal Infirmary (1908–); Resident Physician City of Glasgow Fever Hospital; House Physician Glasgow Royal Maternity and Women's Hospital; MO Nigeria (1914); seconded to RAMC Cameroon (1914–16); RAMC East Africa (1916–19); MO Kenya (1920); DDSS Kenya (1920–33); DMS Kenya (1933–41); retired Kenya; died Kenya

Principal medical interests: medical education; public health

Accolades: CMG (1938); President Kenya Branch BMA (1946–48)

Philp, Horace Robert Andrew (1883–1957)

Nationality: Scottish

Background: unknown

Educated: Royal High School Edinburgh; Edinburgh University

Qualifications: MB ChB (1909)

Family: unknown

Career: House Surg., Deaconess Hospital Edinburgh (1909–c.1910); Missionary, Church of Scotland Mission Kenya (c.1910–1930); Seconded to Colonial Medical Service Kenya (1921–22); Minister Church of Scotland Newcastle (1930–39); Factory Surgeon Newcastle (1939–45); Pastor (1945–55); retired (1955)

Principal medical interests: (campaign against) female circumcision; surgery; medical education

Accolades: unknown

Pugh, John (1882–1972)

Nationality: English

Background: unknown

Educated: St Mary's Hospital;

Qualifications: MRCS, LRCP (1908)

Family: married; one daughter and one son (a doctor)

Career: MO Kenya (1910–20); Served with forces in East Africa (1914–1916); temporary Captain RAMC (1917); SMO Kenya (1920–24); DPMO, Tanzania (1924–30); private practice, London (1930–37); emigrated South Africa (1937); RAMC Kenya (1939–42); South African Medical Corps (1942–45); King Edward VIII Hospital Durban (1945–60); died South Africa

Principal medical interests: trypanosomiasis

Accolades: unknown

Roberts, Clifford Ellis (1899–1961)

Nationality: English

Background: unknown

Educated: Oxford University; London Hospital, LSH&TM

Qualifications: BA, MA (1925); MRCS, LRCP (1925); BM, Bch (1925); DTM&H (1930)

Family: married

Career: residential appointments London and Poplar hospitals (1925–27); MO Uganda (1927–39); Senior Specialist Zanzibar (1939–49), retired Colonial Service (1949); Surgical Officer Ministry of Pensions (1949); SMO Ministry of Pensions (1949–52); medical Superintendent Chapel Allerton Hospital (1952–58); Medical Superintendent Hammersmith Hospital (1958–61); died London

Principal medical interests: surgery

Accolades: FRCS Ed (1936); President Zanzibar Branch BMA [n.d.]; OBE (1945)

Robertson, Muriel (1883–1973)

Nationality: Scottish

Background: father an engineer

Educated: ‘privately’; Glasgow University

Qualifications: MA (1905); DSc (1922)

Family: unmarried

Career: research at Glasgow University; Carnegie Fellow (1907–10); Ceylon (1907); Glasgow (1908); Research Asst., Lister Institute of Preventative Medicine, London (1909–11); MO Uganda for Royal Society Commission (1911–14); Lister Institute (1914–39); Cambridge (1939–44); Head, Department of Protozoology, Lister Institute (1944–c.1950s); part-time worker, Agricultural Research Council Institute of Animal Physiology, Babraham, nr. Cambridge [n.d.]; died Northern Ireland

Principal medical interests: bacteriology; protozoology

Accolades: FRS (1947)

Shircore, John Owen (1882–1953)

Nationality: Scottish

Background: father in Indian Medical Service

Educated: Edinburgh University; Cambridge University; London University

Qualifications: BA, MA [n.d.]; LRCP Ed. LRCS Ed. LFPS Glas.(1906); MB, ChB (1907); MRCP Ed (1911)

Family: unmarried

Career: MO Nyasaland (1908–9); MO Uganda (1909–10); MO Nyasaland (1910–12); SMO i/c Sleeping Sickness Investigation, Nyasaland (1912–13); MO Kenya (1913–19); Captain EAMS (1914–18); DPMO Tanzania (1919–24); PMO Tanzania (1924–32); some work in Borneo [n.d.], returned to Nyasaland Medical Service (1946–8), retired Nyasaland (1948); died Nyasaland

Principal medical interests: yaws; natural history

Accolades: CMG (1926)

Skelton, Dudley Sheridan (1878–1962)

Nationality: English

Background: unknown

Educated: Shrewsbury School; Bonn; London Hospital

Qualifications: MRCS, LRCP [n.d.]; DPH [n.d.]

Family: married Charlotte Nancy (*d.*1944); one son; married (1948) Ursula Joyce

Career: civil surgeon South Africa Field Force (1901–02); RAMC (1902); Ceylon (1903–06); Sierra Leone (1906–08); Somaliland (1908–10); Zanzibar (1912–14); European War (1914–18); Seconded to Colonial Medical Service Tanzania as CSO (1920–22); Seconded to Iraq (1925–27); military postings (1927–47); officiating DMS India, (1937); retired UK; died Kent

Principal medical interests: surgery; bacteriology

Accolades: DSO (1916)

Snell, Douglas Goddard (1908–1987)

Nationality: English

Background: medical family

Educated: Oakham School, Rutland; University College Nottingham; St Thomas' Hospital; Liverpool SH&TM

Qualifications: MRCS, LRCP (1931); MB, BS (1934); DTM&H (1936); DPH (1948)

Family: married (1937) Evelyn; one son and two daughters

Career: House Surg. Ear Nose & Throat Department St Thomas' Hospital; House Surg. & Casualty Officer King George Hospital Ilford (1934–36); MO Uganda (1936–49); SMO Uganda (1949–56); ADMS (1956–60); PMO Uganda (1960–62); Worcester School Health Service (1962–72); retired (1972); churchwarden[n.d.]; died Worcester

Principal medical interests: medical education; public health

Accolades: unknown

Stones, Robert Yelverton (1881–1961)

Nationality: English

Background: unknown

Educated: London Hospital, Liverpool University

Qualifications: MB, BS (1907); DPH (1908); MD (1918); MRCP (1925); DMRE (1930)

Family: married

Career: Missionary, Church Missionary Society Nigeria (1911–13); Church Mission Society Egypt (1913–14); Commissioned to RAMC near East and East Africa (1914–19); Missionary, Church Mission Society Tanzania (1919–24); seconded to Colonial Medical Service Tanzania (1921–22); Missionary Church Mission Society Uganda (1924–39); retired UK; RAMC Malta [n.d.]; later retired Africa; died Uganda

Principal medical interests: ophthalmology; medical education

Accolades: FRCS Ed (1910); MC (c.1918); OBE (1938)

Tothill, Walter Vincent (1886–1954)

Nationality: English

Background: unknown

Educated: London Hospital

Qualifications: LMSSA (1913)

Family: married Bridget Ristori

Career: Ship's Surgeon on routes to Australia (1913–c.14); hospital residencies[n.d.]; RAMC West and East Africa (1914–19); MO Tanzania (1920–22); invalided out of Colonial Service (1922); MO Trinidad [n.d.]; private practice, Australia [n.d.]; MO British Phosphates Commissioners, Nauru Island, Central Pacific [n.d.]; private practice New Zealand [n.d.]; retired South Africa; died South Africa

Principal medical interests: unknown

Accolades: unknown

Trim, Edwin Alfred (1900–1969)

Nationality: English

Background: medical father

Educated: Taunton School; Christ's College, Cambridge; St Thomas' Hospital, LSH&TM

Qualifications: BA, MA [n.d.]; MRCS, LRCP (1925); MB, Bch (1929); DTM&H (1930); MD (1935)

Family: married Rachel

Career: Casualty Officer & House Surg. St. Thomas' Hospital (1925–27); MO Kenya (1927–47); SMO Kenya (1947–49); Asst. DMS Kenya (1949–50); DDMS Kenya (1950–55); DMS Uganda (1955–59); Permanent Sec. Min. and DMS., Min. of Health (1959–61); retired Kenya; died Nairobi

Principal medical interests: schistosomiasis

Accolades: CBE[n.d.]; OBE [n.d.]

Trowell, Hubert Carey (1904–1989)

Nationality: English

Background: father a minister, mother a Baptist missionary

Educated: Reigate Grammar School (1913–23); St Thomas' Hospital;

Qualifications: MB, BS (1928); MD(1932); MRCP (1933)

Family: married Peggy Sifton (1929); one son and three daughters

Career: Casualty Officer and House Phys., St. Thomas' Hospital; House Phys. Royal Berkshire Hospital, Reading (1928–29); MO Kenya (1929–35); MO Uganda (1935–45); Specialist Physician Uganda (1945–54); Senior Specialist Uganda (1954–60); parish priest and hospital chaplain, Wiltshire (1960–69); Research UK (1969–1989); died UK

Principal medical interests: nutrition; medical education

Accolades: FRCP (1945); OBE [n.d.]

Turton, Mary (1889–1958)

Nationality: English (?)

Background: colonial family born South Africa; clerical father

Educated: Edinburgh University

Qualifications: MB, ChB (1915); DPH (1921); DTM&H (1921); MD (1930)

Family: married

Career: Ear Nose & Throat Specialist Malta RAMC (1916–20); MO Royal Herbert Hospital Woolwich (1920–21); Asst. Bacteriologist Uganda (1921–26); Senior

Bacteriologist (1926–37); temporary appointments Essex County Council and Ministry of Pensions (1939–45); retired South Africa (1945); died South Africa

Principal medical interests: bacteriology

Accolades: unknown

Vassallo, Salvator Michael (1891–1953)

Nationality: Maltese (naturalised British)

Background: unknown

Educated: University of Malta; LSH&TM

Qualifications: MD (1913); DTM&H (1922)

Family: married; one daughter

Career: MO leeward Islands (1914–17); Temporary Commission RAMC (1917–19); MO Uganda (1919–25); Resident Surgical Officer, Zanzibar (1925–39); Surgical Specialist RAMC (1939–42); Officer i/c Surgical Division RAMC (1942–48); Senior Surgical Specialist Royal Herbert Hospital Woolwich (1948–52); retired (1952); died Epsom, Surrey

Principal medical interests: surgery; plague; trypanosomiasis

Accolades: FRCS Ed. (1928); President Zanzibar Branch BMA (1929–30, 1934–35);

King's Silver Jubilee Medal (1935); Order of the Brilliant Star Zanzibar (1936);

Coronation Medal (1937)

Wiggins, Clare Aveling (1876–1965)

Nationality: English

Background: father a Justice of the Peace

Educated: Magdalen College School Oxford; Oxford University; St. Mary's Hospital, London, LSH&TM

Qualifications: BA [n.d.]; MRCS, LRCP (1900); Cert. H&TM

Family: married (1904) Ethel Beatrice Elliott; two sons and two daughters

Career: Asst. MO Fulham Infirmary (1900–01); MO Kenya (1901–09); MO Uganda (1909–11); DPMO Uganda (1911–19); Active Service East Africa Campaign (1915–17); PMO Uganda (1919–22); Missionary Church Missionary Society Uganda (1927–31); Missionary Uganda (1938–39); took orders of the Anglican Church (1943); priest South of England (1943–62); died Basingstoke

Principal medical interests: trypanosomiasis; leprosy; medical education; natural history

Accolades: President Uganda Branch BMA (1922); Member of Executive and Legislative Councils for Uganda (1920–23); CMG (1923); Honorary MA Oxford (1942)

Wilcocks, Charles (1896–1977)

Nationality: English

Background: middle-class family, needed a scholarship to go to medical school

Educated: Wigan Grammar School, Manchester University

Qualifications: MB, ChB (1924); MD (1932); DTM&H (1941)

Family: married (1921) (Dr) Frances Bullough

Career: military service (1915–19); general practice, Bolton Lancashire (1924–27); MO Tanzania (1927–30); TB Research Officer, Tanzania (1930–37); Asst. Director

Bureau of Hygiene and Tropical Diseases, London (1938–42); Director Bureau of Hygiene and Tropical Diseases, London (1942–61); Consultant Medical Adviser, Counties Public Health Laboratories (1961–76); retired (1961); died Surrey
Principal medical interests: tuberculosis; bacteriology
Accolades: CMG (1961)

Williams, Arthur Donald John Bedward (1883–1958)

Nationality: English
Background: unknown
Educated: St Paul's School; Caius College, Cambridge; Guy's Hospital
Qualifications: MRCS, LRCP (1910)
Family: unknown
Career: hospital residencies, West London Hospital (1910–1912); MO Kenya (1912–23); served with the forces in East Africa (1914–19); SMO Kenya (1923–28); DDMS Kenya (1928–33); DMS, Nyasaland (1933–38); Colonel, East African Army Medical Corps (1939–1945); retired in Mombasa, Kenya
Principal medical interests: unknown
Accolades: OBE (1919); President Nyasaland Branch BMA (1935–36)

Williams, Arthur Warriner (1905–19??)

Nationality: English
Background: religious family, medical father
Educated: village church school, preparatory school, Oundle School, Peterborough, St John's College, Cambridge
Qualifications: BA (1926); MRCS, LRCP (1929); MB, Bch (1931); DTM&H (1931); MA (1934); MD (1938)
Family: married Molly
Career: House Surg.; Resident Obst. Ast.& House Phys. Children Department, Westminster Hospital; MO Uganda (1931–34); Lecturer Mulago Medical School (1934–44); Dean Mulago Medical School (1945–7); Medical Specialist Tanzania (1947–9); Medical Superintendent Mulago, Uganda (1949–51); Head, (later, Professor), Department of Medicine Mulago, Uganda (1951–61)
Principal medical interests: medical education
Accolades: unknown

Wilson, Christopher James (1879–1956)

Nationality: English
Background: unknown
Educated: St Paul's School; Christ's College, Cambridge; London Hospital; LSH&TM
Qualifications: BA, MA [n.d.]; MRCS, LRCP (1906); MB, Bch (1906); Cert. H&TM [n.d.]; MD (1926)
Family: married
Career: House appointments Royal Portsmouth Hospital; Ship's Surgeon Royal Mail Line; MO tunnel construction company, the Andes; MO Kenya (1911–20); MO Kenya Mounted Rifles (1914–18); SMO Kenya (1920–23); DPMO Kenya (1923–28);

PMO Federated Malay States (1928–31); PMO Straits Settlements (1931–34); retired Colonial Medical Service (1934); retired Kenya; died Nairobi

Principal medical interests: surgery; bacteriology

Accolades: MC (1918); Founder and first editor *Kenya Medical Journal* (1923 later, *East African Medical Journal*); President Malay Branch BMA (1929–30); President Kenya Branch BMA (1938–39); CMG (1939)

Wilson, Donald Bagster (1901–1960)

Nationality: English

Background: unknown

Educated: Monkton Combe School; St. Catherine's College, Cambridge; Birmingham Medical School

Qualifications: MRCS, LRCP (1926); MB, Bch (1927); DTM&H (1929); MD (1935); MRCP (1959)

Family: married (1932) Margaret (Peg) Elizabeth Lovett; two daughters

Career: House Surg. Queen's Hospital Birmingham (1927–29); MO Tanzania (1929–49); Inter-territorial malariologist East Africa i/c East African Institute of Malaria and Insect Borne Diseases (1949–60); retired UK; died Box, Wiltshire

Principal medical interests: malariology

Accolades: OBE (1953)

Wright, Frederick James (1906–1996)

Nationality: English

Background: unknown

Educated: Coopers' Company's School, London; Cambridge University; London Hospital; LSH&TM

Qualifications: BA, MA [n.d.]; MRCS, LRCP (1930); MRCP (1934); MD (1935); DTM&H (1935)

Family: married Ruth and then Gerda; one son and two daughters (one of whom is a doctor)

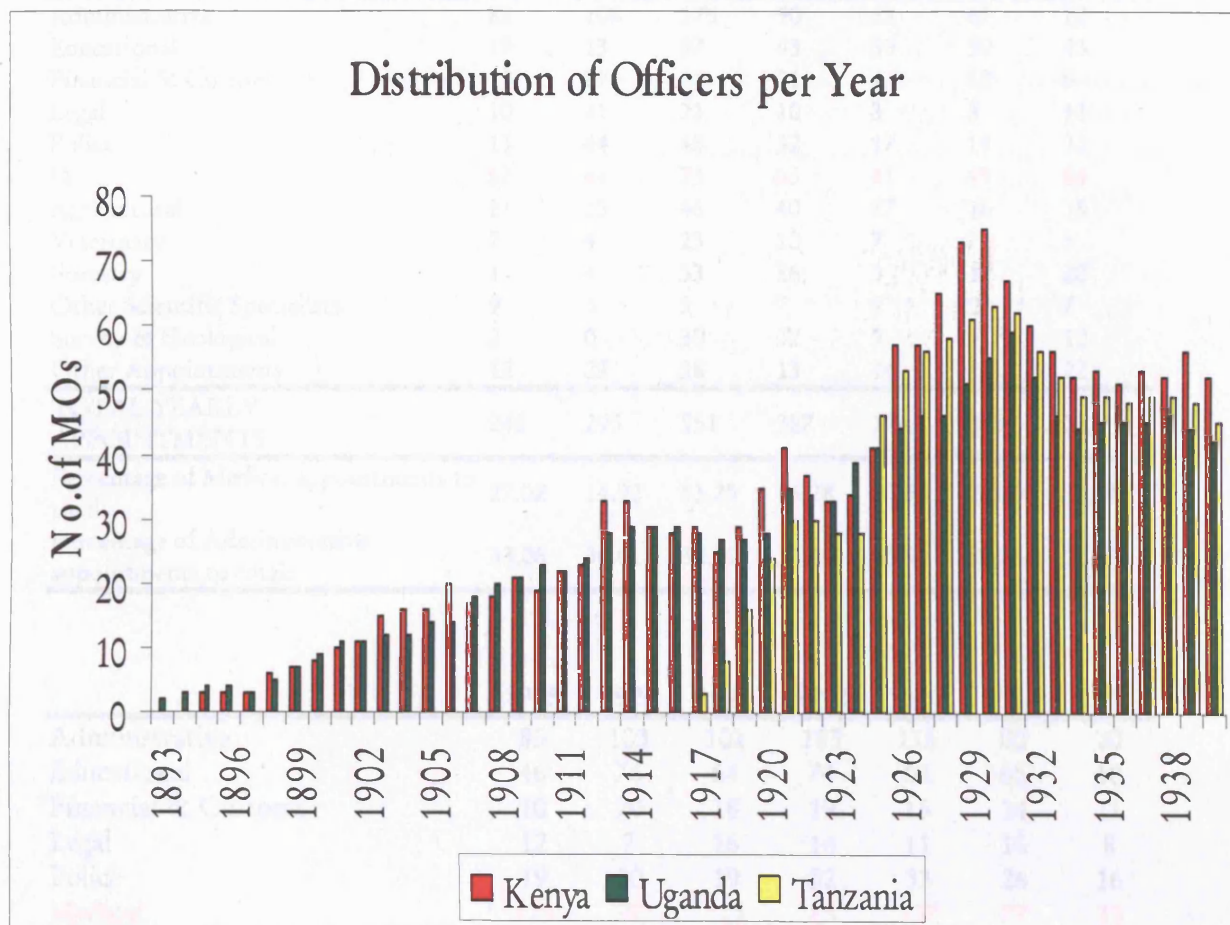
Career: House Phys. & Surg. Out-Patient Clinical Asst., Aural House Surg. & Receiving Room Officer, London Hospital (c.1930–36); MO Kenya (1936–47); Medical Specialist Kenya (1947–53); Senior Lecturer Edinburgh University (1953–4); Consultant in Tropical Medicine Edinburgh (1954–72); Physician i/c Kilimanjaro Christian Medical Centre Tanzania [n.d.]

Principal medical interests: brucellosis; plague; medical education

Accolades: Coronation Medal (c.1948/9); FRCP [n.d.]

Appendix 6

Distribution of Medical Officers in East Africa 1893–1939



Appendix 7

General Colonial Service Recruitment: 1913, 1919-1939

	1913	1919	1920	1921	1922	1923	1924
Administrative	82	108	179	90	18	67	72
Educational	19	13	37	43	39	30	43
Financial & Customs	15	27	31	21	4	12	9
Legal	10	11	21	10	3	8	11
Police	13	44	45	32	17	14	32
Medical	67	44	73	63	41	49	84
Agricultural	11	15	46	40	17	16	35
Veterinary	7	4	23	10	7	7	5
Forestry	1	4	33	26	3	11	20
Other Scientific Specialists	9	3	5	7	2	2	7
Survey & Geological	2	0	30	32	9	5	12
Other Appointments	12	22	28	13	14	12	22
TOTAL YEARLY APPOINTMENTS	248	295	551	387	174	233	352
Percentage of Medical appointments to total:	27.02	14.92	13.25	16.28	23.56	21.03	23.86
Percentage of Administrative appointments to total:	33.06	36.61	32.49	23.26	10.34	28.76	20.45

	1925	1926	1927	1928	1929	1930	1931
Administrative	85	103	101	153	115	80	20
Educational	46	76	64	74	62	65	18
Financial & Customs	10	20	18	19	15	14	11
Legal	12	7	16	14	11	16	8
Police	19	30	19	32	33	26	16
Medical	129	97	121	85	107	77	35
Agricultural	33	30	42	59	42	40	34
Veterinary	8	16	9	11	11	6	3
Forestry	16	13	11	11	13	14	7
Other Scientific Specialists	8	2	18	10	6	8	1
Survey & Geological	15	15	19	27	17	9	3
Other Appointments	25	15	22	12	17	23	9
TOTAL YEARLY APPOINTMENTS	406	424	460	507	449	378	165
Percentage of Medical appointments to total:	31.77	22.88	26.30	16.77	23.83	20.37	21.21
Percentage of Administrative appointments to total:	20.94	24.29	21.96	30.18	25.61	21.16	12.12

	1932	1933	1934	1935	1936	1937	1938	1939
Administrative	25	36	44	67	68	91	96	84
Educational	4	9	7	9	18	14	14	22
Financial & Customs	3	9	21	22	11	10	21	9

Legal	7	8	9	17	22	33	26	8
Police	2	5	10	14	9	19	22	11
Medical	12	22	31	48	53	47	54	54
Agricultural	4	9	23	14	11	28	23	19
Veterinary	0	6	3	5	5	7	8	18
Forestry	4	3	2	5	9	12	12	6
Other Scientific Specialists	4	5	1	4	4	26	24	8
Survey & Geological	0	2	3	7	9	8	10	9
Other Appointments	5	7	11	19	30	11	15	7
TOTAL YEARLY APPOINTMENTS	70	121	165	231	249	306	325	255
Percentage of Medical appointments to total:	17.14	18.18	18.79	20.78	21.29	15.36	16.62	21.18
Percentage of Administrative appointments to total:	35.71	29.75	26.67	29.00	27.31	29.74	29.54	32.94

Compiled from PRO/CO/877/16/21 'Candidates Appointed by the Secretary of State, 1913-1943. Statement Showing the Number of Appointments dealt with by the Appointments Department in the Years 1919-1943'

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RHL/MSS.Afr.a.796 Diary of Charles Wilcocke, 1878-9

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